January 2000 Edition

# Active Projects Report

## RESEARCH AND DEMONSTRATIONS IN HEALTH CARE FINANCING

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**HEALTH CARE FINANCING ADMINISTRATION**

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# Active Projects Report

**Research and Demonstrations in Health Care Financing**

***January 2000 Edition***

Health Care Financing Administration
Office of Strategic Planning

# Foreword

As the Federal agency that administers the Medicare, Medicaid, and State Child Health Insurance Programs, the Health Care Financing Administration (HCFA) directs more than 400 research, demonstration, and evaluation projects to develop and implement new health care payment approaches and financing policies, and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and others. Many of these projects focus on the relationship of payment, coverage, eligibility and management alternatives under Medicare and Medicaid to program expenditures. HCFA's research also examines the quality of health care, alternative health care delivery systems, innovative financing arrangements and cost containment strategies. In addition, HCFA-sponsored studies assess the impacts of Medicare and Medicaid on beneficiaries' health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry also are topics of investigation.

This report is prepared by the Office of Strategic Planning (OSP) to inform customers of HCFA's research. As the planning and research arm of HCFA, OSP coordinates HCFA's research, demonstration, and evaluation activities. OSP conducts research and evaluations and shares responsibility with several other HCFA components in the development and implementation of demonstration projects: the Center for Beneficiary Services, the Center for Health Plans and Providers, the Center for Medicaid and State Operations, and the Office of Clinical Standards and Quality. This report provides basic information on HCFA research, demonstration and evaluation projects active from January 1, 1999, through December 31, 1999. Included are intramural projects conducted by HCFA staff and extramural projects conducted by contractors, grantees, and other awardees with HCFA support.

These research and demonstration project summaries are grouped within five general research themes that reflect HCFA's cross-cutting research priorities during 1998:

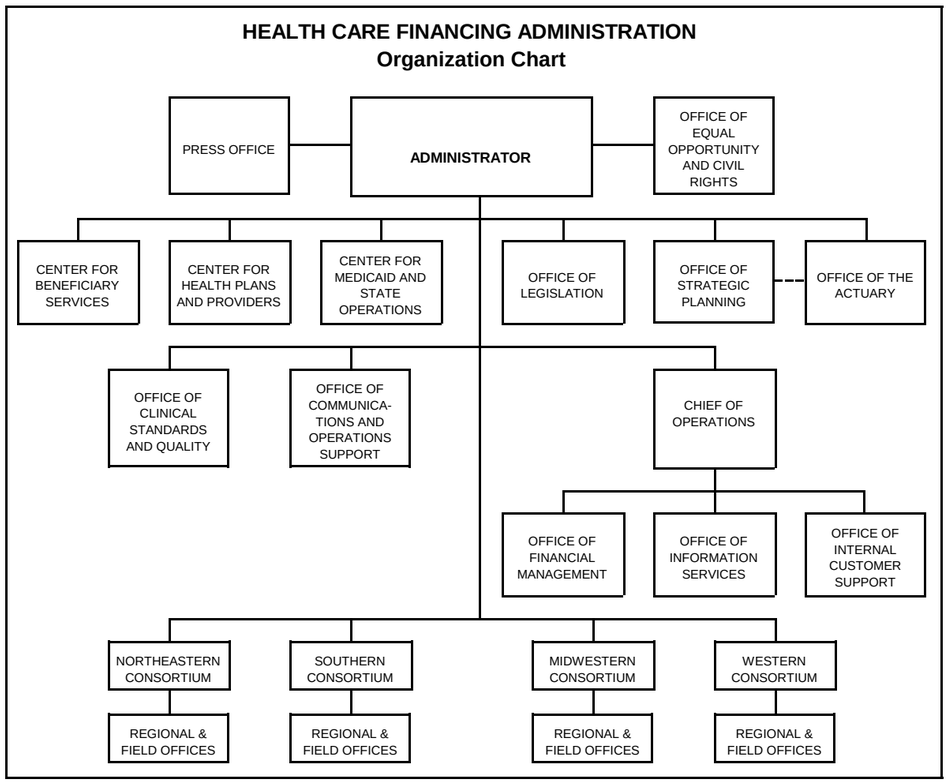
- Theme 1 - Medicare Health Plans: Enrollment, Delivery, and Payment
- Theme 2 - Provider Payment and Delivery Innovation in Traditional Fee-for-Service Medicare
- Theme 3 - Research on the Future of Medicare
- Theme 4 - Outcomes, Quality and Performance
- Theme 5 - Vulnerable Populations, Medicaid and Dual Eligibles

The synopsis of each project includes an identification number, project title, project number, project period, name of principal investigator, and the name and address of its awardee, contractor, or grantee organization. Also included is the name of the Federal project officer with primary responsibility for the project, the Federal statute under which it was conducted (if applicable), the status of the project as of December 31, 1999, and a brief description of each project's goals and its design.

In addition to the descriptions of projects within our five research themes, there is a separate section describing cross-cutting initiatives, as well as summaries of awards under HCFA's Small Business Innovation Research Grant Program; Dissertation Fellowship Grant Program; and research and demonstration task order contracts. Several indices are provided at the back of this book to help readers identify specific projects, principal investigators, awardee organizations and project officers.

This is the twentieth edition of the *Active Projects Report* (formerly the *Status Report: Research and Demonstrations in Health Care Financing*). An updated edition is produced each year.

For more information about HCFA and its research and demonstrations program, visit the HCFA Web site at: **www.hcfa.gov.**


HEALTH CARE FINANCING ADMINISTRATION
Organization Chart
PRESS OFFICE
ADMINISTRATOR
OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
CENTER FOR BENEFICIARY SERVICES
CENTER FOR HEALTH PLANS AND PROVIDERS
CENTER FOR MEDICAID AND STATE OPERATIONS
OFFICE OF LEGISLATION
OFFICE OF STRATEGIC PLANNING
OFFICE OF THE ACTUARY
OFFICE OF CLINICAL STANDARDS AND QUALITY
OFFICE OF COMMUNICA-TIONS AND OPERATIONS SUPPORT
CHIEF OF OPERATIONS
OFFICE OF FINANCIAL MANAGEMENT
OFFICE OF INFORMATION SERVICES
OFFICE OF INTERNAL CUSTOMER SUPPORT
NORTHEASTERN CONSORTIUM
SOUTHERN CONSORTIUM
MIDWESTERN CONSORTIUM
WESTERN CONSORTIUM
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES
REGIONAL & FIELD OFFICES

# Theme 1: Medicare Health Plans: Enrollment, Delivery and Payment

Recent years have seen rapid growth in the number of Medicare beneficiaries receiving their Medicare benefit through private health plans such as health maintenance organizations (HMO). The Balanced Budget Act of 1997 made major changes in the structure of Medicare's contract with private health plans designed to further expand Medicare health plan contracting: it institutes an annual open-enrollment period, expands the types of organizations and delivery systems that can qualify as health plans, and introduces risk adjustment to improve the capitated payment method. These program developments have grown out of HCFA's past research and demonstration program. HCFA's current research agenda includes projects to monitor and evaluate the implementation of the Medicare+Choice program; assessment of HMO performance; demonstrations involving innovative applications of capitated payment; and demonstrations in which Medicare's capitated payment covers both acute- and long-term care services.

IM-077 **A Macro-Economic Analysis of the Medicare+Choice Program**

Funding: Intramural
HCFA Project Director: Edgar A. Peden, Ph.D.
Office of Strategic Planning

Description: This analysis looked at the macroeconomic effects of the Medicare+Choice legislation that became law under the Balanced Budget Act of 1997. The analysis was theoretical, drawing on what economic theory would predict concerning these changes. In addition, it examined selected theoretical and empirical literature which might be relevant for predicting the effects of various parts of the legislation. This analysis was used to supplement other data/analytical evaluation activities already underway.

Status: This project is completed.

IM-107 **Developing a Geographic Price Index for Managed Care**

Funding: Intramural
HCFA Project Directors: Edgar A. Peden, Ph.D., Mark A. Krause, Ph.D., John Robst, Ph.D., and Dylan Supina, Ph.D.
Office of Strategic Planning

Description: Based on the current service-by-service spending patterns of managed care providers, this project is combining current HCFA geographic payment indexes for services together with a number of other geographic indexes from several other Federal agencies to build a county level geographic payment index for managed care plans.

Status: Algorithms are currently being formulated and data sets procured to develop the index.

98-233 **Evaluation System for Medicare+Choice**

Project No.: 500-95-0047/06
Period: September 1998-September 2001
Funding: $746,887
Award: Task Order
Principal Investigator: Lyle Nelson, Ph.D.
Awardee: Mathematica Policy Research, Inc.
600 Maryland Ave., SW., Suite 550
Washington, DC 20024-2512
HCFA Project Officer: Brigid Goody, Sc.D.
Office of Strategic Planning

Description: The Balanced Budget Act of 1997 (P.L. 105-33) makes several changes that affect the eligibility criteria for and payment to health plans contracting with HCFA to provide services to Medicare beneficiaries. The concurrent implementation of several initiatives could have unintended effects on the managed care choices available to Medicare beneficiaries, as well as on the additional benefits provided to beneficiaries and on the quality of care delivered to beneficiaries enrolled in health plans. The purpose of this task order is to design and implement a strategy for tracking and evaluating managed care performance both nationwide and within specific markets across the country during the implementation of the Medicare+Choice provisions. Dimensions of performance to be tracked include

beneficiary access to managed care options, as well as the cost and quality of services delivered to beneficiaries by managed care organizations.

Status: Data preparation and analyses are ongoing. The contractor has prepared exploratory case studies of 12 markets and an interim report containing information on 69 markets representing 74 percent of Medicare managed care enrollees. Dimensions of performance included in these reports are the availability of Medicare managed care organizations, enrollment and disenrollment, and the variation and generosity of benefit offerings. The principal findings of these preliminary analyses indicate that early experience under  varies substantially across markets, especially with respect to contract nonrenewals and the availability and generosity of prescription drug benefits. Future analyses will include additional years' data and expand the dimensions of performance to include access and quality, provider behavior, and financial viability.

99-029 **Selection Bias in Medicare HMOs at Enrollment and Disenrollment**

| | |
|---|---|
| Project No.: | 500-95-0053/03 |
| Period: | May 1999-May 2000 |
| Funding: | $170,882 |
| Award: | Task Order |
| Principal Investigator: | Bryan Dowd |
| Awardee: | University of Minnesota<br>20 Delaware Street, SE.<br>Minneapolis, MN 55455-0392 |
| HCFA Project Officer: | Gerald F. Riley<br>Office of Strategic Planning |

Description: This project consists of several analyses that follow on the work done previously by the University of Minnesota on the Medicare health maintenance organization (HMO) evaluation:

- Selectivity-corrected mortality analyses. These analyses will identify the effect of HMO membership on mortality, rather than interpreting mortality as a health status indicator.
- Do HMOs tend to enroll the people on whom they appear to make the most money? The investigators will calculate the expected cost of people in each adjusted average per capita cost (AAPCC) payment cell, and then compare that average cost to the AAPCC for each cell using the county payment rates and demographic factors. This analysis looks at favorable selection on a cell-by-cell basis, and then determines whether there has been any systematic response of HMOs to variation in cell-by-cell bias.
- What is the effect of prior year expenditures on the probability of joining the HMO? The study will examine whether beneficiaries only consider their short-term health expenditure patterns into account when joining an HMO or take a longer view of their health status.
- How are HMO enrollment and disenrollment related to SES characteristics? Of particular interest is the high disenrollment rate of African Americans from Medicare HMOs.
- Is the amount of time in Medicare managed care a good predictor of utilization in the first year after switching back to fee-for-service Medicare? The study will examine whether age, sex, and time in managed care before switching will explain a significantly greater percentage of the variation in utilization and costs to the Medicare program than age and sex alone.

Status: As of December, 1999, most of the data base will have been assembled and analyses begun.

99-079 **Research on Plan Performance Indicators**

| | |
|---|---|
| Project No.: | 500-95-0057/09 |
| Period: | September 1999-March 2001 |
| Funding: | $773,965 |
| Award: | Task Order |
| Principal Investigator: | Kathryn Langwell |
| Awardee: | Barents Group, LLC<br>2001 M Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officer: | Terry Lied<br>Center for Health Plans and Providers |

Description: The project provides research support that will lead to papers and analyses of plan performance measurement. Papers are to be presented at a 2-day conference. The development of a research plan subsequent to the conference will address issues identified at the conference and site visits. The contractor will conduct research based on the research plan.

Status: In progress.

94-124 **Risk Adjustment of Payment for Mental Health and Substance Abuse**

| | |
|---|---|
| Project No.: | 18-C-90314/1 |
| Period: | October 1994-March 1999 |
| Funding: | $1,056,690 |
| Award: | Cooperative Agreement |
| Principal Investigator: | Richard G. Frank, Ph.D. |
| Awardee: | Harvard Medical School<br>25 Shattuck Street<br>Boston, MA 02115 |
| HCFA Project Officer: | Jay P. Bae, Ph.D.<br>Office of Strategic Planning |

Description: This risk-adjustment research project attempts to study the issues that arise from providing mental health and substance abuse care coverage under a capitation system. There are three main objectives of this project. One objective is to test the ability of three risk classification systems--ambulatory care groups (ACG), diagnostic cost groups (DCG), and payment amount for capitated systems--to explain variation in mental health and substance abuse (MH/SA) costs. The project will modify the existing systems to improve their ability to explain the variation in MH/SA costs. Another objective is to collect information on private-sector cost-sharing arrangements for "carve-out" providers of MH/SA benefits. Using the information, profits and losses of different arrangements will be compared. The third objective is to develop a simulation model that is based on the risk-classification systems and the private-sector cost-sharing arrangements. The project will evaluate the predictive accuracy of the hybrid simulation model for premium-setting purposes.

Status: The project has completed its data analyses using the New Hampshire Medicaid programs. Private insurance data from the William Mercer Co., have also been used to test the performance of alternative risk adjustment systems (e.g., the ACG and DCG Hierarchial Co-existing Conditions classification systems). Results indicate that a modified ambulatory diagnostic group and a comorbidity model performed better, but none of the standard risk-adjustment models achieved $R^2$ values above 0.10. Hence, systematic selection remains a potential problem in a capitated mental health care program. Apart from the data analyses, two theoretical papers have been produced and submitted for publication. One paper written by McGuire and Glazer deals with the concept of optimal risk adjustment that takes into account the degree of asymmetric information in the market. Another paper written by Frank, McGuire, et al., discusses the rationale for carve-outs in MH/SA care. In addition, this project has produced two descriptive papers that report the latest developments in financial risk-sharing arrangements and specific quality standards, such as access, customer service, satisfaction, staffing requirements, etc., for MH/SA care in the managed behavioral health care industry.

94-107 **Alternative Health Risk Adjusters for the Medicare Risk Program**

| | |
|---|---|
| Project No.: | 17-C-90366/3 |
| Period: | September 1994-March 1999 |
| Funding: | $501,581 |
| Award: | Cooperative Agreement |
| Principal Investigator: | Sheldon Retchin, M.D. |
| Awardee: | Virginia Commonwealth University<br>P.O. Box 980568<br>Richmond, VA 23298-0568 |
| HCFA Project Officer: | Jesse M. Levy, Ph.D.<br>Office of Strategic Planning |

Description The goal of this project was to develop a risk adjuster that was based on a history of serious disease (including cancer, heart disease, or stroke) and severity of illness, the length of time since the last hospital stay, and comorbidities. The predictive power from using history of serious illness was compared to the predictive power of two existing risk adjusters--the diagnostic-cost-group and ambulatory-care-group models. Both predictive accuracy and operational features were compared. The study was designed to yield information on the extent to which the health risk adjusters are likely to eliminate over- or underpayment in the Medicare risk program under various assumptions about biased selection in health maintenance organizations.

Status: The final report has been received.

98-230 **Applying JHU ACG/ADG Risk Adjustment Methods to Medicare**

| | |
|---|---|
| Project No.: | HCFA-MOU-96-120 |
| Period: | September 1998-January 2000 |
| Funding: | $123,635 |
| Award: | Contract |
| Principal Investigator: | Jonathan Weiner |

| | |
|---|---|
| Awardee: | The Johns Hopkins University<br>Baltimore, MD |
| HCFA Project Officer: | Andrea Argabrite<br>Office of Clinical Standards and Quality |

Description: This continued earlier work (500-92-0021/02) in which two diagnosis-based risk adjustor models that had potential applicability for Medicare health maintenance organization (HMO) payments were developed. These models were created as alternatives to the adjusted average per capita cost-based system that HCFA has historically used to pay HMOs. With the passage of the Balanced Budget Act of 1997, risk-adjusted payment to HMOs was required and is scheduled to be implemented by calendar year 2000. As a result, HCFA investigated various risk-adjustor algorithms for possible future use with full encounter data obtained from both inpatient and ambulatory sites of service for HMOs. Under this contract, Johns Hopkins University (JHU) provides technical advice and analytic services so that HCFA could better assess and evaluate the "JHU Ambulatory Care Group/Ambulatory Diagnosis Group (ACG/ADG)-HosDom" model as an option for a potential Medicare HMO payment system. Johns Hopkins recalibrated their ACG/ADG-HosDom model using current Medicare data and provided up-to-date software and recalibrations data.

Status: A set of draft programs and a draft final report have been delivered.

96-211 **Refinements to Medicare Diagnostic-Cost-Group Risk Adjustment Models**

| | |
|---|---|
| Project No.: | 500-95-0048/03 |
| Period: | September 1996-June 2000 |
| Funding: | $845,277 |
| Award: | Task Order |
| Principal Investigator: | Gregory C. Pope |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452-8414 |
| HCFA Project Officer: | Melvin J. Ingber, Ph.D.<br>Office of Strategic Planning |

Description: A set of models to provide risk adjuster measures for the purpose of determining payments to capitated managed care organizations has been developed and subsequently improved. Because the Balanced Budget Act of 1997 (BBA) mandated risk adjusters to be used for Medicare+Choice entities in year 2000, this project further updates the models with newer data (1995-1996) and provides better adjustment for factors such as "working aged" and "institutionalized." The updated/new models will also be used to pay plans in the Choices demonstration, if feasible.

Risk adjuster models go beyond demographic information in adjusting payments. Clinical information from medical claims is used to modify payment to reflect the expected expenditures for each enrollee. The diagnostic-cost-group (DCG) family of models is the most mature set of risk adjusters available. DCG models use demographic, diagnostic, and procedure information to project expenditures and to provide adjusters that could be used to multiply the rate book amounts instead of the demographic factors currently used. Among the DCG models are the Principal Inpatient DCG model, which uses hospital data only, and the Hierarchial Co-existing Conditions model, which uses physician and outpatient information as well. It is a hospital-based model that is required for year 2000 by the BBA. Thereafter, an all-claims model should be phased in to adjust payments optimally.

Status: A final report on the hospital-based model was submitted in 1999.

98-264 **Evaluation of the Medicare+Choice Risk Adjustment Method**

| | |
|---|---|
| Project No.: | 440-98-40200 |
| Period: | August 1998-February 1999 |
| Funding: | $24,900 |
| Award: | Purchase Order |
| Principal Investigator: | Bill Bluhm, FSA, MAAA |
| Awardee: | The American Academy of Actuaries<br>1100 17th Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officer: | Frederick G. Thomas III, C.P.A., M.S.<br>Office of Strategic Planning |

Description: The Balanced Budget Act of 1997 (BBA) requires Medicare to implement a risk adjusted payment system for its Medicare+Choice program by January 1, 2000. The BBA requires the Secretary to write a report to Congress that outlines the method of risk adjustment that will be used. An independent actuarial evaluation of the soundness of this method must be attached to this report to Congress. The American Academy of Actuaries will

evaluate the risk methodology and soundness of the proposal and will prepare a report of their findings.

Status: The American Academy of Actuaries has formed a work group to review and evaluate the risk adjuster method. HCFA provided documentation of the methodology, met with the work group, and answered questions posed by the group. The final report was delivered in January 1999.

97-031 **Demonstration of Global Risk-Assessment Models**

| | |
|---|---|
| Project No.: | 17-C-90864/9 |
| Period: | September 1997-September 2000 |
| Funding: | $991,823 |
| Award: | Cooperative Agreement |
| Principal Investigator: | Mark Hornbrook |
| Awardee: | Kaiser Foundation Research Institute<br>1800 Harrison Street<br>Oakland, CA 94612 |
| HCFA Project Officer: | Jay P. Bae, Ph.D.<br>Office of Strategic Planning |

Description: The goal of this project is to develop a risk adjuster covering all age groups and compare different premium setting mechanisms through simulations. The study, funded jointly by HCFA, Robert Wood Johnson Foundation, and Kaiser, uses data from six large not-for-profit health maintenance organizations (HMOs), such as Kaiser Northwest (Oregon), Kaiser Ohio, Kaiser Northeast (Albany, New York), Kaiser Colorado, Health Partners, and Group Health Cooperative of Puget Sound (Washington). The classification system developed at Kaiser, clinical-behavioral diagnosis groups, will be used in a regression model based on diagnoses and demographics. Diagnosis codes from the International Classification of Diseases, 9th Revision, Clinical Modification, are the basis for the system. The classification would reflect HMO practices and could be used to assess the costs of individuals or groups with respect to each other. It is intended that the system could be used to determine capitated payment for Medicare enrollees based on premiums for the non-Medicare population.

Status: During the first year, the project team gathered enrollment and utilization data from all six participating sites and is working to create a data base for further analysis. The major second year activities will include a revision of its existing risk-adjustment group, "Global Risk-Adjustment Model version 93," to version 96, while updating its data base with additional data.

99-040 **Study of Cost-Based Plans**

| | |
|---|---|
| Project No.: | 500-95-0046/02 |
| Period: | August 1999-February 2001 |
| Funding: | $243,647 |
| Award: | Task Order |
| Principal Investigator: | Kathryn Langwell |
| Awardee: | Barents Group, LLC<br>2001 M Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officer: | Tom Hutchinson<br>Center for Health Plans and Providers |

Description: This project provides technical and logistical support to HCFA's Center for Health Plans and Providers in the preparation of a report to Congress on the impact on beneficiaries of discontinuing the Medicare cost-based plans. This report is required by Section 4002(b)(5)(B) of the Balanced Budget Act (P.L. 105-217). The project contains three major tasks:

- Conduct of an analysis of cost-based plans. This includes the geographic distribution of plans and the availability of existing or potential Medicare+Choice (M+C) organizations in these areas and the feasibility of these cost-based plans converting to M+C organizations. This analysis will cover existing HCFA data regarding number of cost plans, geographic location of plans, and availability of other managed care choices for beneficiaries. Included in this analysis should also be an examination of payments made to these plans and a comparison of what would have been paid under an M+C contract. Inherent in this analysis is the estimation of the impact on Medicare beneficiaries if the cost-based plans are discontinued as an election under Medicare. This analysis will form the Secretary's recommendations to Congress "regarding any extension or transition of the contracts."
- Preparation of a working draft of the report to Congress.
- The revision of the working draft using review and comment obtained by the HCFA project officer (from HCFA, the Department of Health and Human Services, the Office of Management and Budget, and other interested parties).

Status: In progress.

IM-037 **Medicare HMO Evaluation**

| | |
|---|---|
| Funding: | Intramural |
| HCFA Project Directors: | Cynthia G. Tudor, Ph.D.<br>Center for Health Plans and Providers<br>Gerald F. Riley, Melvin J. Ingber, Ph.D., and Jay P. Bae, Ph.D.<br>Office of Strategic Planning |

Description: To assess and monitor the Medicare risk program, the Office of Strategic Planning has established an ongoing health maintenance organization (HMO) evaluation program, examining a number of critical issues, including selection and savings, disenrollment patterns, the effect of managed care on costs in the fee-for-service sector (i.e., spillover), beneficiary satisfaction, and quality of care. This evaluation will also update the findings from an earlier study of the Medicare risk HMO program conducted by Mathematica Policy Research, Inc. That study found that HCFA paid 5.7 percent more for HMO enrollees than would have been spent on them under fee-for-service (FFS).

Status: The findings from the analyses include the following:

- Selection and Savings: Using a risk adjustment model to predict the utilization of Medicare risk HMO joiners and disenrollees compared to beneficiaries remaining in FFS, the analyses confirmed findings of favorable selection that used other methods and earlier data. The results indicated that in the year of enrollment, HMO joiners are on average lower users of medical care than the average beneficiary (about 18 percent lower). Disenrollees are higher than average users in the year after disenrollment (about 17 percent higher). The selection estimates varied greatly by county.
- Disenrollment: In 1994, the annual disenrollment rate among Medicare HMO enrollees was 14.2 percent; only 39 percent of these disenrollments went to FFS. The highest disenrollment rates were among vulnerable subpopulations, including Medicaid buy-ins, African American beneficiaries, the disabled under age 65, and the very old. Disenrollment rates were highest in the first months following enrollment, and there was significant variation in disenrollment rates among plans.
- Perceptions of Care: Based on survey data collected in late 1994, this study found no differences between HMO and FFS beneficiaries for most satisfaction measures. However, HMO enrollees were more likely than beneficiaries in FFS to be very satisfied with the costs of their care and getting care at the same location. In contrast, for every measure of the quality of doctor-patient interactions, the findings indicated that HMO enrollees were less likely than FFS beneficiaries to strongly agree with statements about the quality of care provided, including perceptions of the competency of their doctor, his/her understanding of the patient's medical history and what is wrong with the patient, and whether the doctor checks everything.
- Spillover: This analysis examined the effects over time of Medicare and commercial managed care enrollment rates on Medicare FFS expenditures. The results appear inconsistent with the theory of spillover effects, which suggests that physicians change their practice patterns as HMO penetration increases. The results also showed that non-Medicare penetration rates had little effect on the level of Medicare expenditures. In addition, spillover effects appear to be stronger in low penetration markets, with the effects declining as HMO enrollment rates rise. Finally, there seemed to be no evidence of spillover effects in mature HMO markets; rather the effect appeared to be transitory.

96-010 **Medicare Coordinated Open Enrollment**

| | |
|---|---|
| Project No.: | 500-96-0024 |
| Period: | September 1996-September 2000 |
| Funding: | $2,959,970 |
| Award: | Contract |
| Principal Investigator: | Karen Rosenberg |
| Awardee: | Benova, Inc.<br>1220 SW. Morrison, Suite 700<br>Portland, OR 97205 |
| HCFA Project Officer: | Ronald W. Deacon, Ph.D.<br>Center for Health Plans and Providers |

Description: This contract is assisting HCFA in the site development and implementation of the Medicare Competitive Pricing Demonstration mandated in the Balanced Budget Act of 1997. Under this contract, Benova will support HCFA's Center for Health Plans and Providers develop identified sites for the project's implementation. Activities include:

- Meeting with beneficiary advocacy groups, managed care plans, and other local organizations.

- C Preparing analysis of site-specific features to assist in final planning.
- C Adapting prototype beneficiary information materials to the specific features of the intended demonstration sites.
- C Assisting HCFA with beneficiary education and outreach activities.

Status: The contractor assisted with demonstration developmental activities in Kansas City and Phoenix, which were the two sites designated for the demonstration. The Balanced Budget Refinement Act of 1999 prohibits any additional activities in the two sites in fiscal year 2000. Benova will assist with developmental activities in the future, if additional sites are designated.

99-036 **Evaluation of the Competitive Pricing Demonstration--Phase I**

| | |
|---|---|
| Project No.: | 500-95-0048/07 |
| Period: | June 1999-August 2001 |
| Funding: | $458,288 |
| Award: | Task Order |
| Principal Investigators: | Greg Pope and Steven Garfinkel |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452 |
| HCFA Project Officer: | Brigid Goody, Sc.D.<br>Office of Strategic Planning |

Description: Section 4011 of the Balanced Budget Act of 1997, which establishes authority for HCFA to test competitive pricing for Medicare+Choice organizations mandates that "...the Secretary shall closely monitor and measure the impact of the project on the price and quality of, and access to, Medicare covered services, choice of health plans, changes in enrollment, and other relevant factors." The purpose of this phase of the evaluation of the Competitive Pricing Demonstration is to provide HCFA with timely feedback on the implementation and operational experience of each demonstration site. A case study methodology will be used to develop both qualitative and quantitative information required to assess the strengths and weaknesses of the demonstration. The types of questions to be answered during this phase include:

- C How was the bidding process implemented?
- C How did the plans react to the process?
- C Can the process be improved?
- C How smoothly was the demonstration implemented in each site?
- C Were there operational problems for each of the stakeholders and, if so, how were they resolved?
- C How effective were the Area Advisory Committees in their responsibilities to advise on implementation issues?
- C What lessons were learned that could ease implementation in other sites or on a nationwide basis?

Status: The contractor is currently completing a case study of the advisory committee process. Since the implementation of the demonstration has been delayed until January 2002, further evaluation activities are being delayed. This delay will force a change in this contract.

IM-067 **Medical Savings Accounts for Medicare Beneficiaries**

| | |
|---|---|
| Funding: | Intramural |
| HCFA Project Director: | Michael Kendix, Ph.D.<br>Office of Strategic Planning |

Description: Medical savings accounts (MSA) have been proposed as an insurance mechanism that will reduce the growth of expenditure on health services by reducing the moral hazard effect associated with so-called first-dollar coverage. Countervailing this effect is the tendency of certain groups of beneficiaries to select into MSAs, which may result in higher Medicare program expenditures compared to fee-for-service (FFS). A typical MSA has two components--first, a catastrophic plan that covers expenditures above a fixed dollar value; second, an MSA component consisting of funds held by the insured to be used to cover the first dollar amounts of expenditures. The objective of the project was to simulate the effect on Medicare program reimbursement of allowing beneficiaries to choose an MSA. The study used longitudinal data from the Continuous Medicare History Sample, a sub-sample of Medicare beneficiaries' reimbursement and expenditure. The project attempted to calculate and simulate the long-term effects of allowing Medicare beneficiaries to choose an MSA as an alternative to FFS or managed care.

Status: The project is completed. The paper is forthcoming in the journal *Inquiry*.

98-237 **Evaluation of the Medical Savings Account Demonstration**

| | |
|---|---|
| Project No.: | 500-95-0057/06 |
| Period: | September 1998-September 2003 |
| Funding: | $6,546,119 |
| Award: | Contract |
| Principal Investigator: | Ken Cahill |
| Awardee: | Barents Group, LLC/Westat<br>2001 M Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officer: | Michael Kendix, Ph.D.<br>Office of Strategic Planning |

Description: This project evaluates the Medical Savings Account (MSA) Demonstration. It compares the experience of MSA enrollees with other Medicare beneficiaries. The contractor will also act as a coordinator between HCFA and the demonstration participants, including beneficiaries and health plans, in order to ensure that accurate, reliable, and complete data are collected.

Status: In progress.

**MEDICARE CHOICES DEMONSTRATION**

Description: The Medicare Choices Demonstration tests the receptivity of Medicare beneficiaries to a broad range of managed care delivery system options and evaluates the suitability of such options for the Medicare program. The ultimate goal is to provide Medicare beneficiaries with more delivery system choices and to provide HCFA with alternative payment arrangements. The Medicare Choices Demonstration also gives HCFA a head start on developing solutions to a wide range of implementation issues (such as risk sharing, payment methods, certification requirements, and quality monitoring systems) that would be associated with some of the legislative expansions of Medicare managed care under consideration.

*California*

98-266 **Medicare Choices Demonstration: USD Senior Health Plan**

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|---|---|
| Project No: | 95-W-00061/9 |
| Period: | March 1998-February 2001 |
| Award: | Waiver-only Project |
| Principal Investigator | Lisa Ferrari |
| Awardee: | UCSD Healthcare Network<br>200 West Arbor Drive<br>San Diego, CA 92103 |
| HCFA Project Officer: | Joanna Callegary<br>Center for Health Plans and Providers |

*Georgia*

97-242 **Medicare Choices Demonstration: Secure Choice**

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|---|---|
| Project No: | 95-W-00056/4 |
| Period: | September 1997-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Douglas Cueny |
| Awardee: | Georgia Baptist Health Care System<br>100 10th Street, Suite 600<br>Atlanta, GA 30309 |
| HCFA Project Officer: | Cynthia K. Mason<br>Center for Health Plans and Providers |

98-269 **Medicare Choices Demonstration: Medicare Smart**

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|---|---|
| Project No.: | 95-W-00063/4 |
| Period: | April 1998-March 2001 |
| Award: | Waiver-only Project |
| Principal Investigator: | Ronald Hogan |
| Awardee: | St. Joseph's Health System<br>Suite 700<br>5671 Peachtree Dunwoody Road<br>Atlanta, GA 30342-5000 |
| HCFA Project Officer: | Cynthia K. Mason<br>Center for Health Plans and Providers |

*Illinois*

97-245 **Medicare Choices Demonstration: Carle Clinic**

| | |
|---|---|
| Project No: | 95-W-00055/5 |
| Period: | September 1997-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Jeff Ingrum |
| Awardee | Health Alliance Medical Plans, Inc.<br>602 West University Avenue<br>Urbana, IL 61801 |

HCFA Project Officer: Victor G. McVicker
Center for Health Plans and Providers

*Louisiana*

97-247 **Medicare Choices Demonstration: Peoples Health Program (Tenet)**

Project No: 95-W-00054/6
Period: September 1997-September 2000
Award: Waiver-only Project
Principal Investigator: Carol Sullivan
Awardee: New Orleans Regional PHO
200 West Esplanade, Suite 606
Kenner, LA 70065
HCFA Project Officer: Victor G. McVicker
Center for Health Plans and Providers

*Montana*

97-243 **Medicare Choices Demonstration: Yellowstone**

Project No: 95-W-00051/8
Period: February 1997-February 2000
Award: Waiver-only Project
Principal Investigator: Kay Wagner
Awardee: Yellowstone Community
Health Plan, Inc.
1230 North 30th Street, Suite 200
Billings, MT 59101
HCFA Project Officer: Siddhartha Mazumdar, Ph.D.
Center for Health Plans and Providers

*Ohio*

97-246 **Medicare Choices Demonstration: Mount Carmel**

Project No: 95-W-00049/5
Period: February 1997-February 2000
Award: Waiver-only Project
Principal Investigator: Mark Richardson
Awardee: Mount Carmel Health System
793 West State Street
Columbus, OH 43222
HCFA Project Officer: Victor G. McVicker
Center for Health Plans and Providers

*Pennsylvania*

96-217 **Medicare Choices Demonstration: Independence Blue Cross**

Project No: 95-W-00014/3
Period: December 1996-December 1999
Award: Waiver-only Project
Principal Investigator: Anita Jester
Awardee: Independence Blue Cross
1901 Market Street
Philadelphia, PA 19101-7516
HCFA Project Officer: Siddhartha Mazumdar, Ph.D.
Center for Health Plans and Providers

96-215 **Medicare Choices Demonstration: Health Partners of Philadelphia**

Project No: 95-W-00024/3
Period: December 1996-December 1999
Award: Waiver-only Project
Principal Investigator: Jon Aistrop
Awardee: Health Partners of Philadelphia, Inc.
814 Chestnut Street, Suite 900
Philadelphia, PA 19107
HCFA Project Officer: Siddhartha Mazumdar, Ph.D.
Center for Health Plans and Providers

96-216 **Medicare Choices Demonstration: Crozer-Keystone**

Project No: 95-W-00015/3
Period: December 1996-December 1999
Award: Waiver-only Project
Principal Investigator: Bev Slavic
Awardee: Crozer-Keystone Health System
Rose Tree Corporate Center II
1400 N. Providence Road, Suite 4010
Media, PA 19063-2049
HCFA Project Officer: Siddhartha Mazumdar, Ph.D.
Center for Health Plans and Providers

*Texas*

96-214 **Medicare Choices Demonstration: Memorial Sisters of Charity**

Project No: 95-W-00023/6
Period: December 1996-December 1999

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|---|---|
| Award: | Waiver-only Project |
| Principal Investigator: | Joann Dille |
| Awardee: | Memorial Sisters of Charity Health Network<br>9494 Southwest Freeway<br>Houston, TX 77074 |
| HCFA Project Officer: | Joanna Callegary<br>Center for Health Plans and Providers |

*Evaluation*

95-018 **Evaluation of the Medicare Choices Demonstration**

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|---|---|
| Project No: | 500-92-0011/06 |
| Period: | September 1995-June 2000 |
| Funding: | $1,591,240 |
| Award: | Delivery Order |
| Principal Investigator: | Lyle Nelson, Ph.D. |
| Awardee: | Mathematica Policy Research, Inc.<br>600 Maryland Avenue, SW., Suite 550<br>Washington, DC 20024-2512 |
| HCFA Project Officer: | Renee Mentnech<br>Office of Strategic Planning |

Description: HCFA is in the process of implementing the Medicare Choices Demonstration to test the feasibility and desirability of new types of managed care plans for Medicare such as integrated delivery systems and preferred provider organizations. This evaluation project provides a detailed assessment of the overall demonstration project, which looks specifically at beneficiary experiences in the demonstration, cost and use of services within the demonstration sites, and quality of care issues. The evaluation provides some insights into whether the greater range of managed care options offered in this demonstration would be more appealing to the Medicare beneficiaries, and whether issues such as biased selection, high rates of disenrollment, and dissatisfaction exist. In addition, the evaluation project provides continuous monitoring of the demonstration sites, including a comprehensive case study of each of the managed care plans in the demonstration. This part of the evaluation activities focuses on the implementation experience and operational feasibility of the new managed care plans, as well as how plans interact with carriers and HCFA.

Status: The contractor has completed site visits to assess the implementation difficulties the plans have encountered. The first and second interim implementation reports are available. A survey of plan enrollees and a fee-for-service comparison group has also been completed. The survey focuses on reasons for enrolling and disenrolling, enrollees' understanding of their plans, and the enrollees' perceptions of access, quality, and satisfaction. A final report is expected in the summer of 2000.

97-030 **Verification of Encounter Data for Medicare Choices Demonstration**

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|---|---|
| Project No.: | 500-95-0050/02 |
| Period: | September 1997-September 2002 |
| Funding: | $4,223,952 |
| Award: | Task Order |
| Principal Investigator: | Marjorie Hatzman |
| Awardee: | The MEDSTAT Group<br>4401 Connecticut Ave, NW., Suite 400<br>Washington, DC 20008 |
| HCFA Project Officer: | Renee Mentnech<br>Office of Strategic Planning |

Description: This contract assesses and ensures accurate and comprehensive encounter data are reported in the Medicare Choices Demonstration. The project assesses the health plan information systems' capabilities, the overall reasonableness of the encounter data against benchmarks, and the validity of the encounter data against medical record information. On a quarterly basis and for each of the plans participating in the demonstration, a sample of enrollees is selected. The sampling methodology is designed in such a way that there is equal precision across plans and encounter types. The medical records for these enrollees are examined to determine whether the information in the encounters (pseudo-claims) reflects what is in the medical record. Using the medical record, the project assesses the timeliness of the encounter data, the validity of the codes in the encounter data, and the completeness of the information. The medical records are examined to determine whether information on utilization in the medical record is missing from the encounter data base. Fault or error rates are constructed for each claim type and for each health plan overall.

Status: Initial site visits for the data systems' capabilities assessments have been completed. Follow-up visits have been scheduled and are being conducted to provide technical assistance to the plans. The majority of plans have had difficulty submitting encounter data; therefore,

only some of the plans have submitted sufficient data for sampling purposes. The project has completed the first round of validation using medical records from these plans. With technical assistance from the contractor, the amount from and the number of plans submitting encounter data are increasing. Additional samples for the validation of encounter data will be pulled in January and February 2000.

90-023 **United Mine Workers of America Demonstration**

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|---|---|
| Project No.: | 95-C-99643/3 |
| Period: | July 1990-June 2000 |
| Funding: | Waiver-only Project |
| Award: | Cooperative Agreement |
| Principal Investigator: | Russell Crosby |
| Awardee: | UMWA Health and Retirement Funds<br>4455 Connecticut Avenue, NW.<br>Washington, DC 20008 |
| HCFA Project Officer: | Lee Phipps<br>Center for Health Plans and Providers |

Description: The United Mine Workers of America Health and Retirement Funds (the Funds) is a waiver-only demonstration that provides a risk-based Part B capitated payment and some limited Part A coverage for the Funds' Medicare-eligible retirees and dependents. The Funds has established Part B managed care networks in selected areas of Alabama, Pennsylvania, and West Virginia. HCFA has continued the current Part B capitation approach and has implemented risk-sharing for Part A in these three areas. The new waivers also allow for direct admission to nursing homes for Funds beneficiaries. The Funds is expected to encourage preventive care among its population and to substitute less expensive care for Part A whenever appropriate.

Status: The new waivers were awarded, and the project has been ongoing since January 1997.

96-210 **Preparation and Analysis of Department of Defense and Medicare Data in Support of DoD/Medicare Subvention Demonstration**

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|---|---|
| Project No.: | 500-95-0064/02 |
| Period: | July 1996-October 2000 |
| Funding: | $395,032 |
| Award: | Task Order |
| Principal Investigators: | Grace Carter and Edward Fu |
| Awardee: | The RAND Corporation<br>1700 Main Street<br>Santa Monica, CA 90407 |
| HCFA Project Officer: | Jody Blatt<br>Center for Health Plans and Providers |

Description: The project is being carried out by Fu Associates, Ltd., under a subcontract with the RAND Corporation. Fu Associates is merging eligibility and claims data from Medicare and the Department of Defense (DoD) for DoD's beneficiaries with Medicare eligibility in specific geographic areas. We currently have merged data sets for fiscal years 1992-1994 for three 40-mile catchment areas (San Antonio, Texas; Tacoma, Washington; and Lawton, Oklahoma). These data are being expanded to include fiscal years 1995-1998 for the three areas, as well as sites in San Diego, California; Dover, Delaware; Biloxi, Mississippi; and Colorado Springs, Colorado.

Status: After control sites are identified, data will be gathered and merged for these sites.

98-236 **Department of Defense Subvention Demonstration Evaluation**

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|---|---|
| Project No.: | 500-95-0056/06 |
| Period: | September 1998-March 2002 |
| Funding: | $1,411,439 |
| Award: | Task Order |
| Principal Investigator: | Dana Goldman |
| Awardee: | The RAND Corporation<br>1700 Main Street, P.O. Box 2138<br>Santa Monica, CA 90407-2138 |
| HCFA Project Officer: | William J. Sobaski<br>Office of Strategic Planning |

Description: Under the demonstration, enrollment in the Department of Defense's (DoD) Senior Prime plan is offered to military retirees over age 65 who live within 40 miles of the primary care facilities of one of the six sites, have recently used military health facility services, and are enrolled in Medicare Part B. The Senior Prime plans must meet all relevant requirements for Medicare+Choice plans. Medicare makes a capitation payment to DoD for each enrollee, and DoD must maintain a level of effort for health care services to all retirees who are also Medicare beneficiaries, whether or not they choose to enroll, that is based on fiscal year 1996 DoD experience. The evaluation seeks to answer the basic question: can DoD and Medicare implement a

cost-effective alternative for delivering accessible and quality care to military-Medicare-eligible beneficiaries? The evaluation will seek the answer by examining issues in four basic areas:

- Enrollment demand.
- Enrollee benefits.
- Cost of the program.
- Impacts on other DoD and Medicare beneficiaries.

RAND is conducting a process evaluation and a quantitative analysis for the demonstration sites and a set of control sites.

Status: The final report from the evaluation was delivered in April 1999. It is available from the National Technical Information Service (NTIS) (accession number PB 99 149056). The Interim Report conveying results of the process evaluation of the demonstration start-up period was delivered in July 1999. The NTIS accession number is PB99 162505. An annual report for 1999 is due in June 2000. The General Accounting Office (GAO) is also performing an evaluation of this demonstration. It delivered two reports to Congress during 1999 that are available on the GAO website (http:// www.gao.gov). The first was submitted in May 1999 and is numbered GAO/HEHS 99-39. The second one was submitted in September 1999 and is numbered GGD-99-161.

**SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION**

Mandates: Deficit Reduction Act of 1984
Omnibus Budget Reconciliation Act of 1990

Description: In accordance with section 2355 of the Deficit Reduction Act of 1984, the concept of a social health maintenance organization (S/HMO) was developed and implemented. The S/HMO integrates health and social services under the direct financial management of the provider of services. All acute- and long-term care services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Section 4207(b)(4) of the Omnibus Budget Reconciliation Act of 1990 authorized the expansion of the S/Health Maintenance Organization Demonstration. The purpose of this Second Generation S/HMO (S/HMO-II) Demonstration is to refine the targeting and financing methodologies and the benefit design of the current S/HMO model. The S/HMO-II model also provides an opportunity to test more geriatrically-oriented models of care.

84-006 **Social Health Maintenance Organization Project for Long-Term care: Kaiser Permanente Center for Health Research (Formerly, Social Health Maintenance Organization Project for Long-Term Care)**

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|---|---|
| Project No.: | 95-P-09103/0 |
| Period: | August 1984-December 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Lucy Nonnenkamp |
| Awardee: | Kaiser Permanente Center for Health Research<br>3800 North Kaiser Center Drive<br>Portland, OR 97227-1098 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

Description: In accordance with Section 2355 of the Deficit Reduction Act of 1984, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites were selected to participate; of the four, two were health maintenance organizations (HMOs) that have added long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. Kaiser Permanente Center for Health Research (doing business as Senior Advantage II) is one of the HMO sites that developed and added a long-term care component to its service package.

Status: Senior Advantage II (formerly Medicare Plus II) implemented its service delivery network in March 1985. Senior Advantage II uses Medicare waivers only. During the first 30 months of operation, Federal and State governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On four separate occasions, this demonstration has been extended by legislation. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extends the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. This report will address transitioning S/HMOs and similar

plans to the Medicare+Choice program and appropriate payment levels for these organizations. This report is undergoing clearance.

84-004 **Social Health Maintenance Organization Project for Long-Term Care: Elderplan, Inc. (Formerly, Social Health Maintenance Organization Project for Long-Term Care)**

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|---|---|
| Project No.: | 95-P-09101/2 |
| Period: | August 1984-December 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Eli Feldman |
| Awardee: | Elderplan, Inc.<br>6323 Seventh Avenue<br>Brooklyn, NY 11220 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

Description: In accordance with Section 2355 of the Deficit Reduction Act of 1984, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four demonstration sites were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. Elderplan is one of the long-term care provider sites that developed and added an acute-care service component.

Status: Elderplan implemented its service delivery network in March 1985. Elderplan uses both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On four separate occasions, this demonstration has been extended by legislation. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extends the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. This report will address transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. This report is undergoing clearance.

84-007 **Social Health Maintenance Organization Project for Long-Term Care: SCAN Health Plan (Formerly, Social Health Maintenance Organization Project for Long-Term Care)**

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|---|---|
| Project No.: | 95-P-09104/9 |
| Period: | August 1984-December 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Sam Ervin |
| Awardee: | SCAN Health Plan<br>3780 Kilroy Airport Way, Suite 600<br>P.O. Box 22616<br>Long Beach, CA 90801-5616 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

Description: In accordance with Section 2355 of the Deficit Reduction Act of 1984, this project was developed to implement the concept of a social health maintenance organization (S/HMO) for acute- and long-term care. An S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed, annual, prepaid capitation sum. Four sites were selected to participate; of the four, two were health maintenance organizations that have added long-term care services to their existing service packages and two were long-term care providers that have added acute-care service packages. SCAN Health Plan is one of the long-term care provider sites that developed and added an acute-care service component.

Status: SCAN Health Plan implemented its service delivery network in March 1985. SCAN uses both Medicare and Medicaid waivers. During the first 30 months of operation, Federal and State governments shared financial risk with the sites. This risk sharing ended August 31, 1987. On four separate occasions, this demonstration has been extended by legislation. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extends the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. This report will address transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. This report is undergoing clearance.

93-078 **Site Development and Technical Assistance for the Second Generation Social Health Maintenance Organization Demonstration**

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|---|---|
| Project No.: | 500-93-0033 |
| Period: | September 1993-December 2000 |
| Funding: | $2,251,123 |
| Award: | Contract |
| Principal Investigator: | Robert L. Kane, M.D. |
| Awardee: | University of Minnesota<br>420 Delaware Street, SE.<br>Minneapolis, MN 55455-0392 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

Description: In January 1995, HCFA selected six organizations to participate in the Second Generation Social Health Maintenance Organization (S/HMO) Demonstration. The purpose of this project is to study the impact of integrating acute and long-term care services within a capitated managed care system. It was developed to refine the targeting and financing methodologies and the benefit design of the current S/HMO model, which was initiated as a demonstration in 1985.

Although similar services are provided under both of these demonstrations, the Second Generation S/HMO Demonstration features a greater emphasis on geriatric care and a more inclusive case-management system. Another distinguishing characteristic of the project is its risk-adjusted payment methodology that is based on an individual's health status and functioning level. The primary focus of the project's evaluation will be to compare beneficiaries enrolled in the demonstration with beneficiaries in a section 1876 HMO program.

The University of Minnesota and its subcontractor, the University of California at San Francisco, are providing technical assistance and support in the development, implementation, and operation of the Second Generation S/HMO Demonstration.

Status: The developmental phase of the Second Generation S/HMO Demonstration began in January 1995. Since that time the University of Minnesota and the University of California at San Francisco have been providing technical assistance to the organizations participating in the project. They have also developed a questionnaire that is being used to determine a beneficiary's capitated payment rate, a series of geriatric protocols is being used to help physicians identify and treat certain health conditions, and a care coordination assessment instrument is being used to assist case managers with care planning. These technical assistance contractors have made site visits during this time to review the progress of the S/HMO site. They are also assisting a contractor in preparing a S/HMO Transition Report to Congress. The Health Plan of Nevada (HPN) began enrolling beneficiaries in the demonstration in November 1996. HPN enrollment at the end of 1999 was over 35,000 members.

95-088 **Second Generation Social Health Maintenance Organization Demonstration: Nevada**

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|---|---|
| Project No.: | 95-W-90503/9-01 |
| Period: | November 1996-December 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Bonnie Hillegass |
| Awardee: | Health Plan of Nevada, Inc.<br>P.O. Box 15645<br>Las Vegas, NV 89114-5645 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

Status: The Health Plan of Nevada began enrolling Medicare beneficiaries into the S/HMO-II demonstration in November 1996. They continue to participate as an operational site as of December 1999. The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extends the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. This report will address transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations. This report is undergoing clearance.

98-271 **Second Generation Social Health Maintenance Organization Demonstration: Florida**

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|---|---|
| Project No.: | 99-C-90874/4-01 |
| Period: | May 1998-June 2000 |
| Funding: | $150,000 |
| Award: | Cooperative Agreement |
| Principal Investigator: | Charlie Liem |
| Awardee: | Florida Department of Elder Affairs<br>4040 Esplanade Way<br>Tallahassee, FL 32339-7000 |

HCFA Project Officer: James Hawthorne
Office of Strategic Planning

Status: Department of Elder Affairs staff are taking the lead in coordinating planning activities and have assembled a task force comprised of consumers, providers, and representatives from the Maryland State Department of Health and Mental Hygiene to guide the planning process. They have obtained Medicare and Medicaid claims data and are linking these data in an effort to devise a rate-setting mechanism that will work for plans that enroll a disproportionate share of frail elderly. The project is on schedule for the projected completion date of June 30, 2000.

99-131 **Second Generation Social Health Maintenance Organization Demonstration: Maryland**

Project No.: 99-C-90868/3-01
Period: April 1999-June 2000
Funding: $109,211
Award: Cooperative Agreement
Principal Investigator: Martin Wasserman, M.D.
Awardee: Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2793
HCFA Project Officer: James Hawthorne
Office of Strategic Planning

Status: The State has hired staff to coordinate planning activities and has assembled a task force comprised of consumers, providers, and representatives from the Department of Health and Mental Hygiene to guide the planning process. They have obtained Medicare and Medicaid claims data and are linking these data in an effort to devise a rate-setting mechanism that will work for plans that enroll a disproportionate share of frail elderly. The project is on schedule for the projected completion date of June 30, 2000.

95-087 **Second Generation Social Health Maintenance Organization Demonstration: South Carolina**

Project No.: 95-W-90500/4-01
Period: November 1996-December 2000
Award: Waiver-only Project
Principal Investigator: Thomas Brown, Ph.D.
Awardee: Richland Memorial Hospital
Five Richland Medical Park
Columbia, SC 29203-6897
HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

Status: The site has indicated that it is not going forward with implementation of the project.

95-090 **Second Generation Social Health Maintenance Organization Demonstration: Colorado**

Project No.: 95-W-90498/8-01
Period: November 1996-December 2000
Award: Waiver-only Project
Principal Investigator: Margaret Hearndon
Awardee: Rocky Mountain Health Maintenance Organization
2775 Crossroads Boulevard
Grand Junction, CO 81506
HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

Status: As of the end of December 1997, the site had not yet begun implementation.

95-086 **Second Generation Social Health Maintenance Organization Demonstration: Massachusetts**

Project No.: 95-W-90496/1-01
Period: November 1996-December 2000
Award: Waiver-only Project
Principal Investigator: Linda Fitzpatrick
Awardee: Fallon Community Health Plan
Chestnut Place
10 Chestnut Street
Worcester, MA 01608-2810
HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

Status: The site has indicated that it is not going forward with implementation of the project.

95-085 **Second Generation Social Health Maintenance Organization Demonstration: California**

Project No.: 95-W-90493/9-01
Period: November 1996-December 2000
Award: Waiver-only Project

Principal Investigator: Bobbi Baron
Awardee: Contra Costa County Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553-4639
HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

Status: The Balanced Budget Act of 1997 extended the demonstration period through December 31, 2000. The Balanced Budget Refinement Act of 1999 extends the demonstration until 18 months after the Secretary submits the S/HMO Transition Report to Congress. This report will address transitioning S/HMOs and similar plans to the Medicare+Choice program and appropriate payment levels for these organizations.

At the current time, preimplementation activities are underway.

95-091 **Second Generation Social Health Maintenance Organization Demonstration: Florida**

Project No.: 95-W-90501/4-01
Period: November 1996-December 2000
Award: Waiver-only Project
Principal Investigator: JoAnne Dutcher
Awardee: CAC Ramsey Health Plan
75 Valencia Avenue
Coral Gables, FL 33134
HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

Status: The site has indicated that it is not going forward with implementation of the project.

97-210 **Data Collection for Second Generation S/HMO**

Project No.: 500-96-0005/02
Period: November 1996-December 2000
Funding: $4,214,710
Award: Task Order
Principal Investigator: Lisa Maria Alecxih
Awardee: The Lewin Group
9302 Lee Highway, Suite 500
Fairfax, VA 22031-1214
HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

Description: This project consolidates the data collection needs of the Second Generation Social Health Maintenance Organization (S/HMO-II) Demonstration. Work is being performed by Mathematica Policy Research, Inc., under a subcontract. The project is conducting initial and annual follow-up surveys for each beneficiary enrolled in the S/HMO-II demonstration. The information gathered serves three primary functions:

- Baseline and follow-up data for the evaluation.
- Clinical information to the participating S/HMO-II sites for care planning.
- Data for risk-adjustment.

Status: Data collection is underway.

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93-006 **Managing Medical Care for Nursing Home Residents: United HealthCare Corporation, Inc.**

Project No.: 95-C-90174
Period: December 1992-December 2000
Award: Cooperative Agreement
Principal Investigator: Marcia Smith
Awardee: United HealthCare Corporation, Inc.
P.O. Box 1459
Minneapolis, MN 55440-8001
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

Description: This demonstration studies the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners (GNP), who function as primary medical caregivers and case managers. The major goals are to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients are able to be managed safely in nursing homes with expanded services. The operating principal is EverCare, a subsidiary of United HealthCare Corporation, Inc., which receives a fixed capitated payment (based on a percentage of the adjusted average per capita cost) for all nursing home residents enrolled and is at full financial risk for the cost of acute-care services for the enrollees. Six demonstration sites are participating: Boston, Massachusetts; Baltimore, Maryland; Atlanta, Georgia; Denver, Colorado; Phoenix, Arizona; and Tampa, Florida. (No additional sites are planned; total site enrollment is approximately 10,000.) GNPs provide initial assessments of enrollees; make monthly visits; authorize clinic, outpatient, and hospital

visits; and communicate with the patients' physicians, nursing facility staffs, and families. Physician incentive plans are structured to offer a higher reimbursement rate for a nursing home visit and a lower reimbursement rate for services furnished in physicians' offices or in other settings. By increasing the intensity and availability of medical services, EverCare believes that this case-management model will reduce total care costs, improve the quality of care received by participants through better coordination of appropriate acute-care services, and improve the quality of life for and the level of satisfaction of enrollees and their families.

Status: We are working with EverCare to develop quality-of-care measures and payment systems that reflect special populations.

97-216 **Evaluation of the EverCare Demonstration Program**

| | |
|---|---|
| Project No.: | 500-96-0008/02 |
| Period: | September 1997-March 2001 |
| Funding: | $1,544,142 |
| Award: | Task Order |
| Principal Investigator: | Robert L. Kane, M.D. |
| Awardee: | University of Minnesota<br>420 Delaware Street, SE.<br>Minneapolis, MN 55455-0392 |
| HCFA Project Officer: | Kenneth P. Voytek<br>Office of Strategic Planning |

Description: For each EverCare site, of which there are five, two comparison groups will be selected--nonparticipating residents in EverCare site nursing homes and residents in nonparticipating nursing homes operating in EverCare demonstration cities.

Status: Site visits have been made to EverCare and non-EverCare facilities in each of the participating sites. The information gathered was developed into a paper that has been submitted to the gerontologist for review.

97-018 **TLC (formerly Age Well Option)**

| | |
|---|---|
| Project No.: | 18-P-90748/1-01 |
| Period: | May 1997-April 2002 |
| Funding: | $300,000 |
| Award: | Grant |
| Principal Investigator: | Lewis A. Lipsitz, M.D. |
| Awardee: | Hebrew Rehabilitation Center for the Aged<br>1200 Centre Street<br>Boston, MA 02131-1097 |
| HCFA Project Officer: | Renee Mentnech<br>Office of Strategic Planning |

Description: Community care and educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decisionmaking, and chronic disease management. The populations studied are individuals living in the Hebrew Rehabilitation Center for the Aged and those living in subsidized housing in the Boston community. Educational protocols are used to test the hypothesis that clients can be educated and empowered to more actively participate in their own health care planning, decisionmaking, and chronic disease management.

Status: In progress.

**PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY DEMONSTRATION**

| | |
|---|---|
| Mandates: | Omnibus Budget Reconciliation Act of 1986; Omnibus Budget Reconciliation Act of 1987; Omnibus Budget Reconciliation Act of 1990 |

Description: HCFA is mandated by Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g)(1)(2) of the Omnibus Budget Reconciliation Act of 1987 and Section 4744 of Omnibus Budget Reconciliation Act of 1990, to conduct a demonstration that replicates the model of care developed by On Lok Senior Health Services in San Francisco, California. In response to that mandate, the Program of All-inclusive Care for the Elderly (PACE) Demonstration replicates a unique model of managed care service delivery for very frail community-dwelling elderly persons, most of whom are dually eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement, according to the standards established by participating States. The model of care includes, as core services, the provision of adult day health care and multidisciplinary case management through which access to and allocation of all health and long-term care services are arranged. Physician, therapeutic, ancillary, and social support services are provided on site at the adult day health center, whenever possible. Hospital, nursing home, home health, and other specialized services are provided

off site. Transportation is provided for all enrolled members who require it. This model is financed through prospective capitation of both Medicare and Medicaid payments to the provider. Initially demonstration sites assumed financial risk progressively over 3 years; the later sites assumed such risk from day one. The sites listed below, and their State Medicaid agencies, have been granted waiver approval to provide services under this demonstration.

Status: In response to changes in Title XVIII of the Social Security Act made by the Balanced Budget Act of 1997, PACE is being established as a permanent part of the Medicare program and as a State option under Medicaid. It is expected that the demonstration sites will transition from a demonstration to a permanent entity once regulations implementing this public law become effective.

*California*

84-008 **On Lok's Risk-Based Community Care Organization for Dependent Adults**

| | |
|---|---|
| Project No.: | 11-W-00105/9 |
| Period: | November 1983-November 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Louise Nava |
| Awardee: | California Department of Health Services<br>714 P Street, Room 1400<br>San Francisco, CA 94234-7320 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

84-001 **On Lok's Risk-Based Community Care Organization for Dependent Adults: On Lok Senior Health Services**

| | |
|---|---|
| Project No.: | 95-W-00013/98 |
| Period: | November 1983-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Kate O'Malley |
| Awardee: | On Lok Senior Health Services<br>1333 Bush Street<br>San Francisco, CA 94109 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

94-061 **Program of All-inclusive Care for the Elderly: California Department of Health Services**

| | |
|---|---|
| Project No.: | 11-W-00106/9 |
| Period: | May 1994-December 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Louise Nava |
| Awardee: | California Department of Health Services<br>714 P Street, Room 1400<br>Sacramento, CA 94234-7320 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

95-092 **Program of All-inclusive Care for the Elderly: California Department of Health Services**

| | |
|---|---|
| Project No.: | 11-W-00087/9 |
| Period: | May 1995-December 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Della Cabera |
| Awardee: | California Department of Health Services<br>714 P Street, Room 1400<br>Sacramento, CA 95814 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

94-040 **Program of All-inclusive Care for the Elderly: Sutter Health System**

| | |
|---|---|
| Project No.: | 95-W-00005/9 |
| Period: | May 1994-December 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Janet Tedesco |
| Awardee: | Sutter Health System<br>1234 U Street<br>Sacramento, CA 95818 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

95-093 **Program of All-inclusive Care for the Elderly: Center for Elders' Independence**

| | |
|---|---|
| Project No.: | 95-W-00003/9 |
| Period: | April 1995-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | John David Smith |

Awardee: Coalition of Elders' Independence
609 20th Street
Oakland, CA 94612
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

99-002 **Program of All-inclusive Care for the Elderly: AltaMed Senior Buena Care**

Project No.: 95-W-00066/9
Period: November 1998-September 2000
Award: Waiver-only Project
Principal Investigator: Maria Torres, M.D.
Awardee: AltaMed Health Services Corporation
500 Citadel Drive, Suite 490
Los Angeles, CA 90040
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

*Colorado*

98-217 **Program of All-inclusive Care for the Elderly: Colorado**

Project No.: 11-W-00079/8
Period: October 1991-September 1999
Award: Waiver-only Project
Principal Investigator: Carole Workman-Allen
Awardee: Colorado Department of Health Policy and Financing
1575 Sherman Street
Denver, CO 80203
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

98-218 **Program of All-inclusive Care for the Elderly: Total Longterm Care**

Project No.: 95-W-00052/8
Period: October 1991-September 2000
Award: Waiver-only Project
Principal Investigator: David Reyes
Awardee: Total Longterm Care
303 East 17th Street, Suite 650
Denver, CO 80203
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

*Maryland*

99-008 **Program of All-inclusive Care for the Elderly: Johns Hopkins**

Project No.: 95-W-00072/3
Period: March 1999-September 2000
Award: Waiver-only Project
Principal Investigator: Anita Langford
Awardee: Hopkins Elder Care
5505 Hopkins Bayview Circle
Baltimore, MD 21224-2780
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

*Massachusetts*

98-211 **Program of All-inclusive Care for the Elderly: Massachusetts**

Project No.: 11-W-00086/1
Period: June 1986-September 1999
Award: Waiver-only Project
Principal Investigator: Diane Flanders
Awardee: Massachusetts Division of Medical Assistance
600 Washington Street
Boston, MA 20111
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

98-212 **Program of All-inclusive Care for the Elderly: East Boston Geriatric**

Project No.: 95-W-00006/1
Period: June 1989-September 2000
Award: Waiver-only Project
Principal Investigators: Rita Weddleton Lombardi and John Craddock
Awardee: East Boston Geriatric
10 Gove Street
East Boston, MA 02128
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

99-003 **Program of All-inclusive Care for the Elderly: Harbor Health Services, Elder Service Plan**

Project No.: 95-W-00067/1
Period: November 1998-September 1999

Award: Waiver-only Project
Principal Investigator: Rimma Zelfeld
Awardee: Harbor Health Services
Elder Service Plan
2216 Dorchester Avenue
Dorchester, MA 02124
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

99-004 **Program of All-inclusive Care for the Elderly: Cambridge Hospital**

Project No.: 95-W-00068/1
Period: December 1998-September 2000
Award: Waiver-only Project
Principal Investigator: J. Glover Taylor
Awardee: Cambridge Hospital Professional Service Corporation
1531 Cambridge Street
Cambridge, MA 02139
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

99-005 **Program of All-inclusive Care for the Elderly: Fallon Community Health Plan, Elder Service Plan**

Project No.: 95-W-00069/1
Period: December 1998-September 2000
Award: Waiver-only Project
Principal Investigator: Linda Fitzpatrick
Awardee: Fallon Community Health Plan
Elder Service Plan
10 Chestnut Street
Worchester, MA 01608
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

99-129 **Program of All-inclusive Care for the Elderly: Elder Serve Plan of Mutual Health Care**

Project No.: 95-W-00076/1
Period: September 1999-September 2000
Award: Waiver-only Project
Principal Investigator: Charlotte Burrage
Awardee: Elder Serve Plan of Mutual Health Care
1140 Dorchester Avenue
Dorchester, MA 02125-3305
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

*Michigan*

98-207 **Program of All-inclusive Care for the Elderly: Michigan**

Project No.: 11-W-00112/5
Period: May 1997-May 2000
Award: Waiver-only Project
Principal Investigator: Vernon Smith
Awardee: Michigan Department of Social Services
235 S. Cesar Chavez Avenue
Lansing, MI 48909
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

98-208 **Program of All-inclusive Care for the Elderly: Henry Ford**

Project No.: 95-W-00053/5
Period: May 1997-December 2000
Award: Waiver-only Project
Principal Investigator: Laura Seriguichi
Awardee: Henry Ford Health System
11459 Shoemaker Street
Detroit, MI 48213
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

*New York*

98-215 **Program of All-inclusive Care for the Elderly: New York**

Project No.: 11-W-00077/2
Period: September 1989-September 1999
Award: Waiver-only Project
Principal Investigator: Mary Ann Monaco
Awardee: New York Department of Social Services
Room 1466
Corning Tower, Empire State Plaza
Albany, NY 12237
HCFA Project Officer: Michael Henesch
Center for Health Plans and Providers

98-205 **Program of All-inclusive Care for the Elderly: New York**

| | |
|---|---|
| Project No.: | 11-W-00088/2 |
| Period: | May 1990-September 1999 |
| Award: | Waiver-only Project |
| Principal Investigator: | Mary Ann Monaco |
| Awardee: | New York Department of Social Services<br>Room 1466<br>Corning Tower, Empire State Plaza<br>Albany, NY 12237 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

98-206 **Program of All-inclusive Care for the Elderly: Independent Living for Seniors**

| | |
|---|---|
| Project No.: | 95-W-00004/2 |
| Period: | May 1990-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Kathryn McGuire |
| Awardee: | Rochester Memorial<br>2066 Hudson Avenue<br>Rochester, NY 14617 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

98-216 **Program of All-inclusive Care for the Elderly: Beth Abraham**

| | |
|---|---|
| Project No.: | 95-W-00025/2 |
| Period: | September 1989-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Susan Aldrich |
| Awardee: | Beth Abraham<br>612 Allerton Avenue<br>Bronx, NY 10467 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

99-010 **Program of All-inclusive Care for the Elderly: Loretto Independent Living Services**

| | |
|---|---|
| Project No.: | 95-W-00078/5 |
| Period: | April 1999-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Donna M. Handzel |
| Awardee: | Loretto Independent Living Services<br>100 Malta Lane<br>North Syracuse, NY 13212 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

99-130 **Program of All-inclusive Care for the Elderly: Eddy Senior Care**

| | |
|---|---|
| Project No.: | 95-W-00075/2 |
| Period: | September 1999-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Lynn Roughley Young |
| Awardee: | Eddy Senior Care<br>504 State Street<br>Schenectady, New York 12305 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*Ohio*

99-006 **Program of All-inclusive Care for the Elderly: Concordia Care**

| | |
|---|---|
| Project No.: | 95-W-00070/5 |
| Period: | February 1999-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Susan Griffin |
| Awardee: | Concordia Care<br>23763 Euclid Heights Blvd.<br>Cleveland Heights, OH 44106-2797 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

99-009 **Program of All-inclusive Care for the Elderly: TriHealth Senior Link**

| | |
|---|---|
| Project No.: | 95-W-00073/5 |
| Period: | March 1999-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Brian Tilow |
| Awardee: | Bethesda Hospital, Inc.<br>219 Oak Street<br>Cincinnati, OH 45206 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*Oregon*

98-213 **Program of All-inclusive Care for the Elderly: Oregon**

| | |
|---|---|
| Project No.: | 11-W-00095/0 |
| Period: | June 1989-September 1999 |
| Award: | Waiver-only Project |
| Principal Investigator: | Susan Dietsche |
| Awardee: | Oregon Department of Human Resources<br>500 Summer St., NE., Second Floor<br>Salem, OR 97310-1015 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

90-024 **Program of All-inclusive Care for the Elderly: Providence ElderPlace**

| | |
|---|---|
| Project No.: | 95-W-00065/0 |
| Period: | June 1989-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Don Keister |
| Awardee: | Sisters of Providence in Oregon<br>Shared Services Division<br>3510 NE. 122nd Street, Suite 200<br>Portland, OR 97230 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*South Carolina*

98-219 **Program of All-inclusive Care for the Elderly: South Carolina**

| | |
|---|---|
| Project No.: | 11-W-00108/4 |
| Period: | October 1989-September 1999 |
| Award: | Waiver-only Project |
| Principal Investigator: | Nicki Harvey |
| Awardee: | South Carolina Department of Health and Human Services<br>P.O. Box 8206<br>Columbia, SC 29202-8206 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

98-220 **Program of All-inclusive Care for the Elderly: Richland Memorial Hospital - Palmetto Health Alliance**

| | |
|---|---|
| Project No.: | 95-W-00048/4 |
| Period: | October 1989-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Judith Baskins |
| Awardee: | Richland Memorial Hospital<br>Palmetto Health Alliance<br>P.O. Box 2266<br>Columbia, SC 29202-2266 |
| HCFA Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*Tennessee*

99-007 **Program of All-inclusive Care for the Elderly: Hamilton County**

| | |
|---|---|
| Project No.: | 95-W-00071/4 |
| Period: | January 1999-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Viston Taylor |
| Awardee: | Alexian Brothers Community Services<br>425 Cumberland Street, Suite 100<br>Chattanooga, TN 37404 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*Texas*

98-209 **Program of All-inclusive Care for the Elderly: Texas**

| | |
|---|---|
| Project No.: | 11-W-00101/6 |
| Period: | June 1991-September 1999 |
| Award: | Waiver-only Project |
| Principal Investigator: | Anita Anderson |
| Awardee: | Texas Health and Human Services Commission<br>P.O. Box 13247<br>Austin, TX 78711 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

98-210 **Program of All-inclusive Care for the Elderly: Bienvivir Senior Health**

| | |
|---|---|
| Project No.: | 95-W-00007/6 |
| Period: | June 1991-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Rose Goldman |
| Awardee: | Bienvivir Senior Health<br>940 North Carolina Drive<br>El Paso, TX 79915 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*Washington*

99-128 **Program of All-inclusive Care for the Elderly: Providence ElderPlace**

| | |
|---|---|
| Project No.: | 95-W-00064/0 |
| Period: | September 1999-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Michael Whitley |
| Awardee: | Sisters of Providence Health System<br>520 Pike Street, P.O. Box 11038<br>Seattle, WA 98111-9038 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*Wisconsin*

98-221 **Program of All-inclusive Care for the Elderly: Wisconsin**

| | |
|---|---|
| Project No.: | 11-W-00078/5 |
| Period: | November 1989-October 1999 |
| Award: | Waiver-only Project |
| Principal Investigator: | Richard Lorang |
| Awardee: | Wisconsin Department of Health and Social Services<br>1 West Wilson Street<br>Madison, WI 53707-7850 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

98-222 **Program of All-inclusive Care for the Elderly: Community Care for the Elderly**

| | |
|---|---|
| Project No.: | 95-W-00002/5 |
| Period: | November 1989-October 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Paul Soczynski |
| Awardee: | Community Care<br>1555 South Layton Boulevard<br>Milwaukee, WI 53215 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

98-265 **Program of All-inclusive Care for the Elderly: Elder Care Options**

| | |
|---|---|
| Project No.: | 95-W-00062/5 |
| Period: | March 1998-September 2000 |
| Award: | Waiver-only Project |
| Principal Investigator: | Karen Musser |
| Awardee: | Elder Care Options<br>2802 International Lane<br>Madison, WI 53704 |
| HCFA Project Officer: | Michael Henesch<br>Center for Health Plans and Providers |

*Support and Evaluation*

97-016 **Evaluation of the Program of All-inclusive Care for the Elderly**

| | |
|---|---|
| Project No.: | 500-96-0003/04 |
| Period: | April 1997-June 2000 |
| Funding: | $238,917 |
| Award: | Task Order |
| Principal Investigator: | David Kidder, Ph.D. |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officer: | Frederick G. Thomas III, C.P.A., M.S.<br>Office of Strategic Planning |
| Mandates: | Omnibus Budget Reconciliation Act of 1986 |

Description: The Evaluation of the Program of All-inclusive Care for the Elderly (PACE) consists of both qualitative and quantitative components. The purpose of the qualitative component is to examine, in detail, the structure and process of case management as well as to gain a better understanding of the factors that drive interdisciplinary team decisionmaking in the PACE model. Since enrollment in PACE has been lower than originally expected, except for On Lok, the first part of

the quantitative part of the evaluation of PACE is examining the decision to participate in PACE. This is particularly important given the anomaly of under-enrollment in virtually all long-term care alternatives, as well as the policy interest in encouraging increased use of managed care. In the evaluation, the process by which people come to participate in PACE is modeled. The "refusers," or those who apply to PACE and pass the initial screening eligibility criteria but do not actually enroll in the program, serve as the comparison group for the evaluation of the impact of PACE. The impact evaluation of PACE is addressing a broad range of questions including:

- C Does the government spend less on PACE clients than it would have spent on them in the absence of PACE?
- C Does the PACE program spend no more on PACE clients than the capitation amount?
- C Does PACE alter the mix of services provided?
- C Does the quality of life and satisfaction with services increase for participants and family members?
- C Does PACE impact the presence and amount of formal in-home care, formal care outside the home, informal in-home care and informal care outside the home?
- C How does PACE affect the health status and functional status of PACE participants?

Status: All of the data collection for this project has been completed and the contractor is analyzing the impact of PACE on Medicare costs. A final report, entitled "The Impact of PACE on Participant Outcomes," has been received. Briefly, this study found that compared to the comparison group:

- C PACE enrollees had much lower rates of nursing home and inpatient hospital utilization, and higher rates of ambulatory care.
- C PACE enrollees reported better health status and quality of life.
- C PACE participants had lower mortality rates.

The benefits of PACE appeared to be magnified for those participants with high levels of physical impairment. Work continues on the study of the cost effectiveness of PACE, and a final report on this issue is expected before March 2000.

96-056 **Program of All-inclusive Care for the Elderly Quality Assurance**

Project No.: 500-96-0004/02

Period: September 1990-September 2002
Funding: $3,203,917
Award: Task Order
Principal Investigator: Peter W. Shaughnessy, Ph.D.
Awardee: Center for Health Policy Research
1355 S. Colorado Blvd., Suite 306
Denver, CO 80222
HCFA Project Officer: Mary G. Wheeler, M.S., R.N.
Office of Clinical Standards and Quality

Mandates: Balanced Budget Act of 1997

Description: The purpose of this task order is to develop an outcome-based quality improvement (OBQI) system for the Program of All-inclusive Care for the Elderly (PACE) program. The development of the OBQI system consists of two phases. During the first phase, the PACE sites will complete a draft data instrument, developed by the Center for Health Policy and Research, which contains items for outcome measurement and risk adjustment at specific time intervals. From this instrument, site-level reports will be produced summarizing the outcome measures. By comparing site-level case-mix-adjusted outcome reports to other PACE site outcome reports and to the site's previous outcome reports from earlier time periods, the site, HCFA, and the State Medicaid agencies will be able to identify areas that require further examination due to inferior (or perhaps superior) outcomes. In the second phase, the sites will take a closer look at why and how they are achieving specific outcomes and make recommendations for improvements in the case of poor outcomes.

Status: Significant progress has been made in the development of outcome indicators for PACE. The efforts of two clinical panels resulted in a composite list of outcome indicators to be considered for inclusion in the OBQI data set. This list will be used to determine the key outcome indicators for focusing outcome measurement and data item specification activities. Feasibility testing of the proposed data items and data collection protocols began in the winter of 1998. Reliability and validity testing are under development. Pilot testing of the draft data set began in 1999. A report will be prepared summarizing results from the pilot test with recommendations for any changes to the outcome measures and data collection instruments. Using the data from the pilot test, the project will also explore the relationship between patient outcomes and patient

characteristics using the variables recommended for case-mix adjustment.

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**COMMUNITY NURSING ORGANIZATION DEMONSTRATION**

Mandates: Omnibus Budget Reconciliation Act of 1987; Balanced Budget Act of 1997

Description: Section 4079 of the Omnibus Budget Reconciliation Act of 1987 directs the Secretary of Health and Human Services to conduct demonstration projects at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the Community Nursing Organization (CNO) Demonstration are capitated payment and nurse-case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute-care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. Four applicants were awarded site demonstration contracts on September 30, 1992. The selected sites represent a mix of urban and rural sites and different types of health providers including a home health agency, a hospital-based system, and a large multispecialty clinic. The four sites are identified below.

Status: All four CNO demonstration sites underwent a 1-year development period and began a 3-year operational period in January 1994. The Balanced Budget Act of 1997 extends the demonstration period through December 31, 1999. Abt Associates, Inc., was competitively selected to evaluate the project and to provide technical assistance to the four CNO sites. Abt also was competitively awarded the external quality assurance contract.

92-070 **Community Nursing Organization Demonstration: Carle Clinic Association**

| | |
|---|---|
| Project No.: | 500-92-0053 |
| Period: | September 1992-December 1999 |
| Funding: | $1,786,629 |
| Award: | Contract |
| Principal Investigator: | Cheryl Schraeder, Ph.D. |
| Awardee: | Carle Clinic Association<br>307 East Oak, Suite 3<br>P.O. Box 718<br>Mahomet, IL 61853 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

92-071 **Community Nursing Organization Demonstration: Carondelet Health Services, Inc.**

| | |
|---|---|
| Project No.: | 500-92-0055 |
| Period: | September 1992-December 1999 |
| Funding: | $878,413 |
| Award: | Contract |
| Principal Investigator: | Gerri Lamb, Ph.D. |
| Awardee: | Carondelet Health Services, Inc.<br>Carondelet St. Mary's Hospital<br>1601 West St. Mary's Road<br>Tucson, AZ 85745 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

92-072 **Community Nursing Organization Demonstration: Living at Home/Block Nurse Program**

| | |
|---|---|
| Project No.: | 500-92-0052 |
| Period: | September 1992-December 1999 |
| Funding: | $1,102,096 |
| Award: | Contract |
| Principal Investigator: | Linda Robertson |
| Awardee: | Living at Home/Block Nurse Program<br>Ivy League Place, Suite 225<br>475 Cleveland Avenue North<br>St. Paul, MN 55104 |
| HCFA Project Officer: | Thomas Theis<br>Center for Health Plans and Providers |

92-073 **Community Nursing Organization Demonstration: Visiting Nurse Service of New York**

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|---|---|
| Project | 500-92-0054 |
| Period: | September 1992-December 1999 |
| Funding: | $945,282 |
| Award: | Contract |
| Principal Investigator: | Ruth Mitchell |
| Awardee: | Visiting Nurse Service of New York<br>107 East 70th Street<br>New York, NY 10021-5087 |

HCFA Project Officer: Thomas Theis
Center for Health Plans and Providers

94-038 **Community Nursing Organization Demonstration External Quality Assurance**

Project No.: 500-92-0014/04
Period: June 1994-January 1999
Funding: $535,304
Award: Delivery Order
Principal Investigator: David Kidder, Ph.D.
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: Renee Mentnech
Office of Strategic Planning

Description: The purpose of this project was to conduct an external review of the quality of health care delivered to Medicare beneficiaries participating in the Community Nursing Organization (CNO) Demonstration (a risk-reimbursed coordinated care program for home health and selected ambulatory services). The CNO Demonstration External Quality Assurance project included a quarterly review of client medical records for a sample of clients receiving Medicare-covered mandatory CNO services, and a quarterly review of CNO assessments and provision of CNO interventions on a sample of all enrollees. Under this project, the awardee was responsible for monitoring the quality of care management and health education services provided through the CNO and implementing corrective actions, when necessary. The quality of traditional Medicare home health services was monitored. The awardee also conducted a use review of the home health services provided to enrollees to validate or support changes in capitation payment rates. The evaluation contractor was provided with documentation of the findings and interventions of the quality assurance process.

Status: This contract was extended to match the extended demonstration periods which were triggered by the Balanced Budget Act. A final report was submitted.

92-068 **Evaluation of the Community Nursing Organization Demonstration**

Project No.: 500-92-0050
Period: September 1992-September 1999
Funding: $3,014,634
Award: Contract
Principal Investigator: Robert J. Schmitz, Ph.D.
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: James Hawthorne
Office of Strategic Planning

Description: The Community Nursing Organization (CNO) Demonstration was mandated by Section 4079 of the Omnibus Budget Reconciliation Act of 1987. The legislation directs the Secretary of Health and Human Services to conduct a demonstration project at four or more sites to test a capitated, nurse-managed system of care. The two fundamental elements of the CNO are capitated payment and nurse-case management. These two elements are designed to promote timely and appropriate use of community health services and to reduce the use of costly acute- care services. The legislation mandates a CNO service package that includes home health care, durable medical equipment, and certain ambulatory care services. The CNO sites receive a monthly capitation payment for each enrollee. The capitation rate is modeled on the adjusted average per capita cost-payment method used for Medicare health maintenance organizations. The CNO per-capita payment rate is set at a level that is equal to 95 percent of the adjusted average per capita Medicare payment for community and ambulatory services in the CNO's geographic area. The legislation mandates the use of two types of CNO per-capita payment methods. Payment Method A adjusts the per-capita payment according to an individual's age, gender, and prior home health use. Payment Method B adjusts the per-capita payment according to an individual's functional status in addition to age, gender, and prior home health use. The evaluation of the CNO demonstration examines the feasibility and effect on patient care of these capitated, nurse case-managed service-delivery models. Both qualitative and quantitative components are included. The qualitative component uses a case study approach to examine the operational and financial viability of the CNO model. The quantitative component uses a randomized design to measure the impact of the CNO intervention on mortality, hospitalization, physician visits, nursing home admissions, and Medicare expenditures, as well as on such nurse-sensitive outcomes as knowledge of health problems and management of care. The four CNO demonstration sites began the operational period in January 1994, and collection of baseline data for CNO enrollees began immediately. Site visit reports

summarizing site activities have been completed. The Balanced Budget Act caused these demonstrations to be extended, so the evaluation also was extended.

Status: A final report on the evaluation of the demonstration, using data from January 1994 through October 1997, has been submitted to HCFA and is in clearance. However, in the Balanced Budget Refinement Act of 1999, Congress mandated a 2-year extension of the demonstration and called for additional evaluation. A report on this supplemental evaluation is due in July 2001.

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## Theme 2: Provider Payment and Delivery Innovations in Fee-for-Service Medicare

HCFA's research program has a long history of developing payment methods that encourage more cost-effective delivery of care. Our current research and demonstration activities include attempts to better align providers' incentives to deliver cost-effective care either through payment innovations such as bundled payment models or prospective payment systems for post-acute care. Other initiatives include competitive bidding and experiments to foster coordinated care.

95-017 **Medicare Competitive Pricing Demonstrations**

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|---|---|
| Project No.: | 500-92-0014/05 |
| Period: | September 1995-September 2000 |
| Funding: | $3,000,000 |
| Award: | Delivery Order |
| Principal Investigator: | Robert Coulam, Ph.D., J.D. |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officer: | Ronald W. Deacon, Ph.D.<br>Center for Health Plans and Providers |

Description: Abt Associates, Inc., and its subcontractor, the University of Minnesota, are assisting HCFA in the design, development, and implementation of Medicare Competitive Pricing Demonstrations. In these demonstrations, HCFA replaces the existing fee-for-service-based health maintenance organization (HMO) payment system with a market-based pricing system. All competing Medicare HMOs in designated metropolitan statistical areas are asked to bid a capitation price that is required to provide a pre-defined benefit package. HCFA arrays the bids, selects a payment level, and pays all HMOs this government contribution. Payments are adjusted to reflect enrollee risk characteristics.

Status: The contractor developed several option papers for decisions on demonstration design and site selection. A Competitive Pricing Advisory Committee (CPAC) met several times and selected a demonstration design and sites for the demonstration using the information supplied by Abt and its subcontractors. Abt also prepared several option papers for two local Area Advisory Committees in Kansas City and Phoenix. Abt will continue to develop required informational papers for the CPAC process.

95-055 **Per-Case Payment to Encourage Risk Management and Service Integration in the Inpatient Acute-Care Setting**

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|---|---|
| Project No.: | 500-92-0013/05 |
| Period: | September 1995-September 1999 |
| Funding: | $511,408 |
| Award: | Delivery Order |
| Principal Investigator: | Janet Mitchell, Ph.D. |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452-8414 |
| HCFA Project Officer: | Mark Wynn<br>Center for Health Plans and Providers |

Description: The purpose of this project is to design a demonstration, conduct a solicitation, and provide technical assistance during the implementation of a per-case payment system. Discounted lump-sum payments based on each participating physician hospital organization's historical payment experience for all diagnosis-related groups will be made to the representative organization. The demonstration sites will be called Medicare physician provider partnerships. The demonstration seeks to measure actual provider behavioral response, patient satisfaction, health outcomes, and overall impact on the Medicare program, given a financial risk-sharing intervention for acute Medicare Part A and Part B inpatient services. This demonstration is intended to provide important understanding about the administrative complexities, their associated costs, and other implementation issues surrounding a medical staff payment approach. This demonstration builds on research conducted under two prior studies (500-92-0020DO07 and 18-C-90038/3) investigating alternative payment options for medical staffs that would promote efficiency and improve service delivery during acute inpatient stays.

Status: The contractor has assisted HCFA in soliciting sites for the demonstration and in providing technical assistance to the sites. Operation of the demonstration was delayed by computer systems issues and is scheduled to start in 2001.

97-033 **Participating Centers of Excellence Demonstration Evaluation**

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|---|---|
| Project No.: | 500-95-0058/04 |
| Period: | September 1997-December 2001 |
| Funding: | $400,000 |
| Period: | Task Order Contract |
| Principal Investigator: | Jerry Cromwell, Ph.D. |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452-8414 |
| HCFA Project Officer: | Mark A. Krause, Ph.D.<br>Office of Strategic Planning |

Description: HCFA is conducting a Medicare Participating Centers of Excellence Demonstration for Orthopedic and Cardiovascular Services. The demonstration tests the feasibility and cost effectiveness of negotiated bundled-payment arrangements for selected inpatient procedure episodes. The payments, at a minimum, will cover all inpatient hospital and physician services for demonstration patients for defined procedures. This contract is for the evaluation, which will assess the overall performance of the participating centers. It will look at the use of systems for administration, claims processing and payment, and the routine monitoring and improvement of quality of care at these centers.

Status: HCFA has postponed the implementation of this demonstration indefinitely due to computer systems issues.

IM-096 **Evaluation of Using DRGs in an Inpatient Prospective Payment System for Exempt Psychiatric Hospitals and Distinct-Part Units**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director: | Frederick G. Thomas III, C.P.A., M.S.<br>Office of Strategic Planning |

Description: Stays in psychiatric hospitals and distinct-part psychiatric units have dramatically declined over the last decade. As a result of this change, the original concerns over excluding these providers from the general hospital prospective payment system may no longer be relevant. This project compared the length of stays of psychiatric diagnosis-related groups (DRG) in general hospitals in 1987 to stays in psychiatric hospitals and distinct-part units in 1997. If exempt hospital stays approach the levels experienced by the general hospitals a decade earlier, there may be a potential to use DRGs in a per-case payment system.

Status: Completion expected in June 2000.

IM-103 **Risk Adjusting Capitation Payments for Health Plans that Target Functionally Impaired Medicare Beneficiaries**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director: | Gerald F. Riley<br>Office of Strategic Planning |

Description: Medicare policymakers are concerned about the adequacy of diagnosed-based risk adjusters for establishing payments for health plans that disproportionately enroll frail beneficiaries. The Medicare Current Beneficiary Survey for 1991-1994 was used to examine the ability of the Principal Inpatient Diagnostic Cost Group and Hierarchical Co-existing Condition models to predict Medicare costs for groups defined by institutional status and difficulty with activities of daily living. The analysis examines the distribution of Medicare expenses by type of service for different functional impairment levels and the role of home health and skilled nursing facility expenses in producing patterns of under- and overprediction.

Status: A paper has been written and accepted for publication by the *Health Care Financing Review*.

94-097 **Demonstration of Managed Care Under Medicare Using Volume Performance Standards Organizations**

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|---|---|
| Project No.: | 95-C-90388/1 |
| Period: | September 1994-January 1999 |
| Funding: | $1,206,693 |
| Period: | Cooperative Agreement |
| Principal Investigator: | Christopher P. Tompkins, Ph.D. |
| Awardee: | Brandeis University<br>415 South Street<br>Waltham, MA 02254-9110 |
| HCFA Project Officer: | Cynthia K. Mason<br>Center for Health Plans and Providers |

Description: The purpose of this project was to demonstrate the physician group-specific volume performance standard (GVPS) model, which creates a partial risk-sharing arrangement between participating physician-sponsored groups and HCFA under the fee-for-service (FFS) program. To participate, the group would have to meet quality and other standards, and submit case management and other clinical strategies to improve the clinical management and coordination of care for selected types of high-cost patients. Each group would operate under FFS. At the end of each year, the group's actual case-mix-adjusted performance would be compared to its per-capita target, based on the group's historical experience, updated by a rate-of-growth factor. The difference between the target and actual performance would be considered Medicare savings. While the target would be based on all Medicare reimbursements per unique patient seen by the group, the bonus formula for Medicare savings would be constrained by the percent of total services actually provided by the group. This percentage is called the patient-capture ratio. A second multiplier would be a predetermined percent amount of savings that HCFA would share. Finally, the total bonus payment would be capped. Groups would be provided with profiles of their utilization to assist in meeting their targets in a clinically cogent manner. The goals of this demonstration included the following:

- Testing whether selected physician organizations can improve the efficiency and delivery of services to Medicare beneficiaries in the FFS sector.
- Testing and refining reimbursement and incentive systems that reward providers for delivering care efficiently.
- Developing new techniques for using information for organizational and clinical decisionmaking (profiling) to facilitate controlling costs without sacrificing quality or access to care.
- Targeting GVPS models at selected physician group practices that could represent "best practices" and provide clinical and managerial leadership toward the objective of improved efficiency in the FFS market.
- Developing and testing the feasibility of the required administrative infrastructure.

This demonstration followed research and development of the GVPS model under two prior studies (99-C-98526/1 and 17-C-90129/1).

Status: This cooperative agreement expired without the demonstrations being initiated.

96-081 **Evaluation of Group-Specific Volume Performance Standards Demonstration**

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|---|---|
| Project No.: | 500-95-0048/04 |
| Period: | September 1996-April 2001 |
| Funding: | $2,212,887 |
| Period: | Task Order |
| Principal Investigator: | Janet Mitchell, Ph.D. |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452-8414 |
| HCFA Project Officer: | Cynthia K. Mason<br>Center for Health Plans and Providers |

Description: The purpose of this task order is to comprehensively evaluate the Group-Specific Volume Performance Standards (GVPS) Demonstration. Additionally, there is a group of tasks to provide technical support for setting sites' targets and measuring their actual performance. The goal of the demonstration is to test the feasibility of this partial-risk-bearing payment arrangement between HCFA and qualifying physician-based organizations in the fee-for-service (FFS) market, whereby FFS rules apply within the context of a performance target, beneficiaries are not enrolled, and physician-sponsored organizations develop structures and processes to manage the services and cost of care received by FFS patients.

Status: In developing the final design parameters of the GVPS demonstration, simulations were conducted to analyze low and high expenditure outliers, eligibility mix changes, components of growth rates by type of service, and effects of case-mix adjustments. These analyses reveal sources of variability in growth rates, and support development of options for setting targets and calculating updates and bonus payments. The evaluator is awaiting the initiation of the demonstration.

98-227 **Medicare Coordinated Care**

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| Project No.: | 500-95-0047/04 |
| Period: | July 1998-October 2000 |
| Funding: | $637,746 |
| Award: | Task Order |
| Principal Investigator: | Don Lara |
| Awardee: | Mathematica Policy Research, Inc.<br>600 Maryland Avenue, SW., Suite 550<br>Washington, DC 20024-2512 |

HCFA Project Officer: Catherine Jansto
Center for Health Plans and Providers

Description: This task order provides technical and logistical support to HCFA in developing potential Medicare Coordinated Care Demonstration projects as required by Section 4016 of the Balanced Budget Act of 1997.

Status: In November 1998, a *Federal Register* notice announcing the project's intent to collect information on Best Practices in Coordinated Care was published. In March 1999, a *Federal Register* notice was published that solicited information from the public. Information and comments were received in June 1999. Written or electronic comments are to be sent to the contractor. The review of Best Practices was received in late 1999. HCFA intends to solicit proposals from potential sites in 2000.

99-068 **Aging in Place: A New Model for Long-Term Care**

Project No.: 18-C-91036/7
Period: June 1999-June 2003
Funding: $609,534
Award: Cooperative Agreement
Principal Investigator: Karen Dorman Marek, Ph.D.
Awardee: University of Missouri - Columbia
Sinclair School of Nursing
310 Jesse Hall
Columbia, MO 65211
HCFA Project Officer: Barbara Silverman, M.D.
Office of Strategic Planning

Description: The goal of the "Aging in Place" model of care for frail elderly is to allow elders to remain in their homes as they age, rather than requiring frequent moves to allow for more intensive care if and when it becomes necessary. The University of Missouri's Sinclair School of Nursing is in the process of implementing such a model. Although a planned element of the program is a new senior housing development, the program currently targets elderly residents of existing congregate housing. The University has received a grant in the amount of $2 million in support of the evaluation of this model of care.

Status: A first-year award was made to the applicant subject to revision of the study design and work plan according to terms and conditions established by the review panel. HCFA staff met with the Principal Investigator and other members of the research team at a kick-off meeting on September 1, 1999, at which time a revised work plan and budget were submitted. As a result of changes to the study plan, the applicant requested an increase in the first-year award with a corresponding reduction in the Years 2-4 awards and no change in the total budget. This change was approved.

98-223 **Hospital Malpractice Insurance Self-Funding Premium Survey**

Project No.: 500-98-0005
Period: September 1998-September 2000
Funding: $278,230
Award: Contract
Principal Investigator: Joshua Park
Awardee: ANASYS, Inc.
10450 Shaker Drive, Suite 113
Columbia, MD 21046
HCFA Project Officer: Benson L. Dutton
Office of Strategic Planning

Description: HCFA has historically used data on hospital malpractice premiums produced by the American Hospital Association and from the Medicare Hospital Cost Reports. This contract will replace the former activity, providing HCFA with current hospital malpractice premium data collected directly from partially or fully self-insured hospitals. It is estimated that approximately 570-580 hospitals will be involved. Mail and phone survey techniques will be used.

Status: The Office of Management and Budget forms clearance package has been approved, sample selection completed, and data collection begun. Analysis will commence once data collection has been completed and draft and final reports have been delivered.

**MUNICIPAL HEALTH SERVICES PROGRAM**

Description: Development of the Municipal Health Services Program (MHSP) was a collaborative effort of four major cities, the U.S. Conference of Mayors, the American Medical Association, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978, to each of these cities: Baltimore, Cincinnati, Milwaukee, and San Jose. HCFA joined the project by providing Medicare and Medicaid waivers to test the

effects of increased utilization of municipal health centers by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. The intent of the waivers is to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.

Status: MHSP waivers, which started in June 1978, were scheduled to terminate on December 31, 1984; however, HCFA agreed to extend them through December 1985. After 1985, Congress extended the demonstration several times. In the Balanced Budget Act of 1997, Congress extended the demonstration until December 31, 2000, but required that no new beneficiaries be allowed to participate in the demonstration. It also required that each demonstration city implement a transition plan that provides a smooth transition from demonstration to nondemonstration status. The Balanced Budget Reconciliation Act of 1999 extended the transition phase until December 31, 2002.

HCFA contracted with Mathematica Policy Research, Inc., to perform an independent evaluation of the demonstration. The evaluator reported that the MHSP program had grown considerably since 1985 in terms of cost and utilization. A review of the cost reports indicated that a large proportion of the increase in program costs was caused by the rise in the utilization of high-cost ancillary services, e.g., prescription drugs, dental care, and vision care.

*Baltimore, Maryland*

97-201 **Municipal Health Services Program: Baltimore, Maryland**

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|---|---|
| Project No.: | 95-P-51000 |
| Period: | August 1979-December 2002 |
| Award: | Service Agreement |
| Principal Investigator: | Bernadette G. Greene |
| Awardee: | City of Baltimore<br>111 North Calvert Street<br>Baltimore MD 21202 |
| HCFA Project Officer: | Ronald W. Deacon, Ph.D.<br>Center for Health Plans and Providers |

*San Jose, California*

97-202 **Municipal Health Services Program: San Jose, California**

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| Project No.: | 95-P-51000 |
| Period: | August 1979-December 2002 |
| Award: | Service Agreement |
| Principal Investigator: | JoAnn Foreman |
| Awardee: | City of San Jose<br>151 West Mission Street<br>San Jose, CA 95110 |
| HCFA Project Officer: | Ronald W. Deacon, Ph.D.<br>Center for Health Plans and Providers |

*Milwaukee, Wisconsin*

97-203 **Municipal Health Services Program: Milwaukee, Wisconsin**

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|---|---|
| Project No.: | 95-P-51000 |
| Period: | August 1979-December 2002 |
| Award: | Service Agreement |
| Principal Investigator: | Samuel Akpan, Ph.D. |
| Awardee: | City of Milwaukee<br>841 North Broadway<br>Milwaukee, WI 53202 |
| HCFA Project Officer: | Ronald W. Deacon, Ph.D.<br>Center for Health Plans and Providers |

*Cincinnati, Ohio*

97-204 **Municipal Health Services Program: Cincinnati, Ohio**

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| Project No.: | 95-P-51000 |
| Period: | August 1979-December 2002 |
| Award: | Service Agreement |
| Principal Investigator: | Malcolm P. Adcock, Ph.D. |
| Awardee: | City of Cincinnati<br>3101 Burnet Avenue<br>Cincinnati, OH 45229 |
| HCFA Project Officer: | Ronald W. Deacon, Ph.D.<br>Center for Health Plans and Providers |

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88-016 **Medical Assistance Facility Demonstration Project**

Project No.: 95-C-99292/8
Period: June 1988-September 1999
Funding: $140,939
Period: Cooperative Agreement
Principal Investigator: Keith McCarty
Awardee: Montana Hospital Research and Education Foundation
P.O. Box 5119
Helena, MT 59604
HCFA Project Officer: Siddhartha Mazumdar, Ph.D.
Center for Health Plans and Providers

Description: The Montana Hospital Research and Education Foundation (MHREF) is conducting a demonstration of the medical assistance facilities (MAF). The MAF is a new category of licensure in Montana for health care facilities providing emergency, outpatient, and low-intensity acute-care services to short-term inpatients. MAFs are intended to maintain accessibility to basic acute- and emergency-care services and provide limited inpatient care for no longer than 96 hours. These facilities are located in counties with fewer than six residents per square mile or in areas more than 35 miles from the nearest hospital. MAFs maintain agreements with larger full-service hospitals and other providers to ensure the availability of a full network of services.

Status: The project served as a prototype in the development of the Essential Access Community Hospital program. HCFA and MHREF have developed conditions of participation and certification requirements, quality assurance and use review procedures, and payment systems for MAFs. Twelve MAFs are operating currently in Montana. The Balanced Budget Act of 1997 created the national "Critical Access Hospital Program," which is intended to subsume these projects.

99-062 **Hospital Outpatient Prospective Payment System: Development of Volume Performance Standards and a Hospital Outpatient Market Basket**

Project No.: 500-95-0058/11
Period: September 1999-July 2000
Funding: $410,303
Award: Task Order
Principal Investigator: Elizabeth Kulas, Ph.D.
Awardee: Health Economics Research, Inc.
411 Waverley Oaks Rd., Suite 330
Waltham, MA 02452-8414
HCFA Project Officer: Barbara Lutz
Center for Health Plans and Providers

Description: In the fall of 1998, HCFA published a proposed rule to establish a prospective payment system (PPS) for hospital outpatient services and partial hospitalization services furnished by Community Mental Health Centers (CMHCs). A final rule has not yet been published. The authorizing legislation sets requirements for updating the PPS rates through 2002 and gives HCFA the authority to develop a hospital outpatient market basket for payment updating after 2002. The law also requires HCFA to develop a method for controlling unnecessary increases in the volume of covered services paid under the PPS. This project will help HCFA construct a market basket specific to hospital outpatient services. The market basket will be used to annually update the payment rates for outpatient services under PPS, including partial hospitalization services in CMHCs. This market basket will be similar to that used in updating Medicare payment for hospital inpatients.

The project will also help determine a feasible long term methodology for controlling unnecessary volume increases in hospital outpatient services and in partial hospitalization services furnished in CMHCs paid under the hospital outpatient PPS. With the exception of ambulance and outpatient rehabilitation services (which are subject to separate fee schedules), the law provides the Secretary the authority to determine which services are included under the hospital outpatient PPS. Under the proposed PPS, HCFA will set payment rates for services based on groups of services rather than individual services. The PPS consists of about 300 such groups that are related both clinically and in level of resource use. These groups are called ambulatory payment classifications. We have proposed to package the ancillary costs integral to furnishing a procedure or visit into the PPS payment. Payment for laboratory tests and radiology services would be made in addition to the payment for a surgical procedure or medical visit.

In the proposed rule, we set out an initial volume control measure, discussed several long term alternatives to controlling volume, solicited comments, and advised that we would propose a method for determining volume controls for services furnished in calendar year (CY) 2001 and subsequent years after completing further analysis. For CY 2000, we will modify the physician sustainable growth rate (SGR) system and incorporate it into the hospital outpatient PPS. Using this approach, we would create incentives to constrain unnecessary utilization in future years tied directly to the established

hospital outpatient expenditure target for 2002. We would calculate an outpatient SGR value--the payment update in 2002 would be reduced if volume increases result in expenditures above the target level. The outpatient SGR system would base volume and intensity growth allowances on growth in the general economy. Other factors would include medical inflation, changes in enrollment, and changes in spending due to changes in the law or regulations.

While the short term approach would potentially reduce the inappropriate growth in hospital outpatient department payments, to the extent that volume is physician driven, it could be criticized as unnecessary and unfairly penalizing facilities. Moreover, because sites of ambulatory care are relatively interchangeable with respect to services, setting appropriate targets for hospital outpatient services alone could be difficult. For these reasons, we believe it is essential that we analyze options for developing a long term integrated approach. One long term strategy would expand the SGR system applied to physician services to take into account hospital outpatient services. This approach would provide added incentives for physicians to evaluate the necessity of orders for hospital outpatient services.

Status: The project is in the early stages. Another possible strategy would expand the SGR system for physician services to include all ambulatory settings, e.g., services furnished in hospital outpatient departments and Medicare certified ambulatory surgical centers. This strategy would be used to update the facility payments as well as the physician fee schedule payments. It would spread volume control incentives more evenly across the ambulatory sector. Further, it would more closely align physician and facility incentives and be less sensitive to shifts in site of service than a hospital outpatient department-only SGR.

**NEW YORK MEDICARE GRADUATE MEDICAL EDUCATION PAYMENT DEMONSTRATION**

Description: In 1997, a number of New York State teaching hospitals volunteered to reduce the number of resident physicians in training by 20 to 25 percent over a 5-year period, in return for transition payments for a portion of the Medicare payments that are foregone when the number of full-time equivalent interns and residents declines. The hospitals entered the demonstration as part of a consortium, as joint projects, and as individual institutions. A substantial number have since withdrawn.

98-229 **Design for Evaluation of the New York Medicare Graduate Medical Education Payment Demonstration and Related Provisions in P.L. 105-33, the Balanced Budget Act of 1997**

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|---|---|
| Project No.: | 500-98-0003 |
| Period: | September 1998-March 1999 |
| Funding: | $173,052 |
| Award: | Contract |
| Principal Investigator: | Jerry Cromwell, Ph.D. |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452 |
| HCFA Project Officer: | William J. Sobaski<br>Office of Strategic Planning |

Description: This contract provided recommendations for designing an evaluation of HCFA waivers provided to several New York State teaching hospitals in 1997. These hospitals volunteered to reduce the number of resident physicians in training by 20 percent or more over a 5-year period, in return for transition payments for a portion of the Medicare payments that are foregone when the numbers of full-time equivalent interns and residents declines. In developing the design for evaluating this initial phase of the demonstration, the contractor also provided recommendations on how to evaluate the second phase of the New York demonstration and for evaluating the effects of the provisions in the Balanced Budget Act of 1997 which concern graduate medical education, particularly Section 4626, "Incentive Payments under Plans for Voluntary Reduction in the Number of Residents," and Section 4628, "Demonstration Project on Use of Consortia." The Health Services and Resources Administration of the Department of Health and Human Services co-funded this project.

Status: The final report was received. We anticipate awarding a contract to perform the evaluation beginning in the summer of 1999.

99-054 **Evaluation of the New York Medicare Graduate Medical Education Payment Demonstration and Related Provisions**

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|---|---|
| Project No.: | 500-95-0058/10 |
| Period: | September 1999-September 2004 |
| Funding: | $1,692,751 |
| Award: | Task Order |
| Principal | |

Investigator: Jerry Cromwell, Ph.D.
Awardee: Health Economics Research, Inc.
411 Waverley Oaks Rd., Suite 330
Waltham, MA 02452-8414
HCFA Project Officer: William J. Sobaski
Office of Strategic Planning

Description: Medicare's annual graduate medical education (GME) spending reached $7 billion, of which nearly 20 percent was for New York teaching hospitals. This is a coordinated evaluation of a major demonstration which provided incentives for New York State teaching hospitals to reduce their residencies by 20 to 25 percent over a 5-year period, and several provisions of the Balanced Budget Act of 1997 (BBA) which were also aimed at reducing Medicare GME spending. The evaluation assesses the impacts of residency reduction on access and service delivery as well as the economic and workforce effects. This is a follow-on project to the design effort; thus, the work is being performed in the manner described in the "Design for Evaluation of the New York (NY) Medicare GME Demonstration and Related Provisions in P.L. 105-330 (BBA): Recommended Design and Strategy for NY GME Demonstration and National BBA GME Provisions" (available from the National Technical Information Service, accession number PB99-175063). Specifically, the project will present a series of reports as follows:

- C A statement of the expressed goals and objectives of HCFA in formulating and implementing the NY GME payment demonstration and the contractor's plans for evaluating the extent to which these are met, and any consequences and concerns that resulted in the near term.
- C A description of the types of information which policymakers outside of HCFA desire about the effects of the following provisions of the BBA:
  - Voluntary Reduction Program.
  - Consortia Demonstration.
  - Reduced indirect medical education (IME) adjustment factor.
  - Capped resident to bed ratio.
  - Three-year moving average full-time equivalent (FTE) resident count.
  - Counting certain resident patient care activity time in nonhospital IME payment per Medicare+Choice (M+C) discharge.

  For Direct GME (DGME):
  - Cap on number of allopathic and osteopathic FTE residents.
  - Special rules for new facilities.
  - Special rules for training programs established on or after January 1, 1995.
  - Special rules for facilities that meet needs of underserved rural areas.
  - Three-year rolling average FTE count.
  - Five-year phase-in for counting inpatient days of (M+C) enrollees.
  - DGME payments to nonhospital providers.
  - Limit on reimbursable training period for primary care combined residency programs.
  - Revised formula for cost outliers in teaching hospitals and disproportionate share hospital providers.
- C A description of the processes used by New York teaching hospitals in deciding whether to apply for participation in the demonstration. The report should consider and seek to identify both the commonalities in these practices and any particularly unique circumstances that influenced these decisions.
- C A description of the implementation status of the provisions included in report 2 and the kinds of preliminary evaluation information that are available about each.
- C A description of the processes used to decide on the specific plans of participating hospitals for implementing the proposed resident reduction plans, and the plans for restructuring its GME training program and for adjusting the staffing configurations and service delivery arrangements.
- C A description of the participants in the BBA Voluntary Reduction Program and a comparison with the participants in the NY GME demonstration.
- C A description of the extent to which national policymakers outside of HCFA were influenced by the NY GME demonstration when developing the provisions in the BBA that changed Medicare's payment policies for GME.
- C A projection of the expected impact of resident caps and the 3-year rolling average provisions of sections 4621 and 4623 on Medicare payments to teaching hospitals.
- C A description of the kinds of information wanted by national policymakers outside of HCFA about the NY GME demonstration and the extent to which the operating data from the demonstration will be able to provide the desired information.
- C A description of trends in teaching hospital involvement in (M+C) plans.
- C A summary report on the NY GME demonstration during the period from July 1, 1997 through June 30, 2000.

- A description of Medicare payments for nonhospital graduate medical training provided by hospitals or other qualified organizations.
- A description of the changes that participating sites made in service delivery, patient management arrangements, staffing, and workload distribution.
- A description of changes in the size and specialty composition of the GME enterprise in the United States between 1997 and 2000.
- A summary of the changes in payment arrangements, payer-mix, payer-type, managed care plan involvement and financial conditions of the sites during the period from 1997 to 2001.
- Ad hoc reports that provide information about provisions for GME that are of expressed interest to national health policymakers.

Status: The project is underway. The principal subcontractor is Massachusetts General Hospital Institute of Health Policy and Harvard Medical School. The Center for Health Workforce Studies at State University of New York, Albany will provide consultative services. The project has a technical advisory panel of experts in the GME field including leadership staff from national organizations representing GME interests and concerns, researchers and policy analysts with expertise in health workforce issues, researchers expert in studying access and quality of care, and economists who have studied GME financing policy. The panel will be convened periodically by Health Economics Research, Inc., for advice and reactions about the evaluation design and strategy and to discuss factors that may influence the direction of the project.

97-249 **New York Graduate Medical Education Demonstration: Buffalo Consortium**

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|---|---|
| Project No.: | 95-W-00027/2 |
| Period: | February 1997-[open] |
| Award: | Waiver-only Project |
| Awardee: | Millard Fillmore Health System |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

Consortium Members: Buffalo General Hospital, Children's Hospital of Buffalo, Erie County Medical Center, Mercy Hospital, Millard Fillmore Hospital, Niagra Falls Memorial Hospital, Roswell Part Cancer Institute, and Sisters Hospital.

97-250 **New York Graduate Medical Education Demonstration: Mount Sinai Consortium**

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|---|---|
| Project No.: | 95-W-00038/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Mount Sinai Medical Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

Consortium Members: Cabrini Medical Center, Elmhurst Hospital Center, Mount Sinai Medical Center, and Queens Hospital Center.

Status: Cabrini, Elmhurst, and Mount Sinai withdrew as of March 10, 1999. Queens was considering remaining in the demonstration.

97-251 **New York Graduate Medical Education Demonstration: New York University Consortium**

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|---|---|
| Project No.: | 95-W-00042/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | New York University Medical Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

Consortium Members: Bellevue Hospital Center, Brooklyn Hospital Center, Hospital for Joint Diseases, Lenox Hill Hospital, New York University (NYU) Downtown Hospital, and NYU Medical Center.

Status: Bellevue, Joint Diseases, Lenox Hill, NYU Downtown, and NYU Medical Center withdrew. Brooklyn was considering remaining in the demonstration.

97-241 **New York Graduate Medical Education Demonstration: Rochester Consortium**

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|---|---|
| Project No.: | 95-W-00058/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | University of Rochester Medical Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

Consortium Members: The Genessee Hospital, Highland Hospital of Rochester, Park Ridge Hospital, Rochester General Hospital, St. Mary's Hospital, and Strong Memorial Hospital.

Status: The entire consortium withdrew as of October 1998.

97-252 **New York Graduate Medical Education Demonstration: Jacobi Medical Center and North Central Bronx Hospital Joint Project**

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|---|---|
| Project No.: | 95-W-00030/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Jacobi Medical Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-253 **New York Graduate Medical Education Demonstration: Maimonides Medical, Coney Island Hospital and Interfaith Medical Center Joint Project**

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|---|---|
| Project No.: | 95-W-00035/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Maimonides Medical Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

Status: Coney Island informed the Project Officer that they would withdraw June 30, 1999.

97-254 **New York Graduate Medical Education Demonstration: Westchester Medical Center, Sound Shore Medical Center and Mount Vernon Hospital Joint Project**

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|---|---|
| Project No.: | 95-W-00040/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Westchester Medical Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

Status: Westchester and Sound Shore withdrew March 1, 1999.

97-256 **New York Graduate Medical Education Demonstration: Harlem Hospital Center**

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|---|---|
| Project No.: | 95-W-00029/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Harlem Hospital Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-257 **New York Graduate Medical Education Demonstration: Kings County Hospital Center**

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|---|---|
| Project No.: | 95-W-00031/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Kings County Hospital Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-239 **New York Graduate Medical Education Demonstration: Lincoln Medical and Mental Health Center**

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|---|---|
| Project No.: | 95-W-00033/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Lincoln Medical and Mental Health Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-259 **New York Graduate Medical Education Demonstration: Long Island Jewish Medical Center**

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|---|---|
| Project No.: | 95-W-00034/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Long Island Jewish Medical Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-260 **New York Graduate Medical Education Demonstration: Metropolitan Hospital Center**

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|---|---|
| Project No.: | 95-W-00036/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Metropolitan Hospital Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-261 **New York Graduate Medical Education Demonstration: New York Eye and Ear Infirmary**

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|---|---|
| Project No.: | 95-W-00043/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | New York Hospital and Presbyterial Hospital |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-232 **New York Graduate Medical Education Demonstration: Woodhull Medical and Mental Health Center**

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|---|---|
| Project No.: | 95-W-00047/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Woodhull Medical and Mental Health Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

97-240 **New York Graduate Medical Education Demonstration: Bronx-Lebanon Hospital Center**

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|---|---|
| Project No.: | 95-W-00039/2 |
| Period: | February 1997-[Open] |
| Award: | Waiver-only Project |
| Awardee: | Bronx-Lebanon Hospital Center |
| HCFA Project Officer: | Joseph M. Cramer<br>Center for Health Plans and Providers |

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99-050 **Alternatives to the 96-Hour Rule for Critical Access Hospitals**

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|---|---|
| Project No. | 500-95-0057/08 |
| Period: | September 1999-June 2000 |
| Funding: | $140,967 |
| Award: | Task Order |
| Principal Investigator: | Kathryn Langwell |
| Awardee: | Barents Group, LLC/Westat<br>2001 M Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officer: | George Morey<br>Center for Health Plans and Providers |

Description: This project will undertake the research needed for the report to Congress on alternatives to the 96-hour rule for certain diagnosis-related groups (DRGs) treated in critical access hospitals (CAHs). The Balanced Budget Act of 1997 established a Medicare Rural Hospital Flexibility Program. This program preserves health care infrastructure in small rural communities by providing access to existing primary care services and by enabling hospitals to provide limited acute care services to rural Medicare beneficiaries, especially emergency care services. These institutions are called CAHs. This replaces the Essential Access Community Hospital/Rural Primary Care Hospital program which operated as a seven-State demonstration. CAHs must be located more than a 35-mile drive from another hospital or CAH (in mountainous areas or those with only secondary roads, the distance minimum is 15 miles), have 24-hour emergency care, have no more than 15 inpatient beds (swing-bed CAHs are allowed up to 25 beds); and keep each inpatient no longer than 96 hours, unless a longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions, or a peer review organization or equivalent entity waives the 96-hour limit on an individual-case basis.

There is a requirement that the Secretary report on the feasibility of an alternative (for certain medical diagnoses) to this 96-hour limit. Prior research on alternatives to an hourly limit on stays was done in 1993 and involved a review of patient records by a physician panel to identify the diagnoses believed suitable for treatment in a limited-service setting. Since this prior work was not designed to supplement hourly limits but to find an alternative to them, it is necessary to undertake this current project. The current project will start by identifying a data base of patient stays in critical access hospitals, Montana medical assistance facilities, and other small rural hospitals similar in size and scope of operations. The data base will not be limited to Medicare cases but will include all patients regardless of payer. Within that data base, the project will identify those stays which were longer than 96 hours. Next will be the selection of cases in which patients stayed longer than 96 hours for clinical reasons, rather than because of nonclinical factors such as inclement weather. Those cases will be examined for characteristics affecting DRG assignment--e.g., age, sex, primary diagnosis, secondary diagnosis, complications or comorbidities, and procedures performed. The cases will be assigned to DRGs and the project will identify, by frequency of occurrence, the DRGs responsible for stays in excess of 96 hours. The analysis will compare the resource consumption for those cases with the resource consumption of the cases in which patients stayed less than 96 hours, and identify those DRGs, if any, whose stays exceeded 96 hours but had resource consumption similar to stays of 96 hours or less.

There will be a review, on a sample or other selective basis, of the cases in DRGs selected above, in order to assess the severity of those cases in relation to the severity of cases involving stays of 96 hours or less and to identify DRGs that involve stays of more than 96 hours but are similar in terms of resource consumption and severity to cases with shorter stays and produce good

patient outcomes, i.e., DRGs which can appropriately be treated in small or limited-service hospitals. Based on analysis and clinical review, a preliminary report of findings and recommendations will be prepared indicating which DRGs could be allowed to be treated in CAHs without regard to the 96-hour limit.

Status: In progress.

99-055 **Study of the Effect of Implementing the Post Acute Transfer Policy Under the Inpatient PPS**

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|---|---|
| Project No.: | 500-95-0058/06 |
| Period: | September 1999- March 2000 |
| Funding: | $114,039 |
| Award: | Task Order |
| Principal Investigator: | Boyd Gilman |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452 |
| HCFA Project Officer: | Dan McGrane<br>Center for Health Plans and Providers |

Description: This project is an assessment of the effects of implementing the provision that certain hospital discharges to post-acute-care settings be treated as transfers. This assessment is directed by Section 4407 of the Balanced Budget Act of 1997 (BBA) (P.L. 105-33), which specifies that the Secretary should publish a description of the effects of the transfer policy in the inpatient prospective payment system proposed rule for fiscal year (FY) 2001. The study examines the effects of the transfer policy change on facility lengths of stay, costs, and payments in both acute- and post-acute-care settings. The prospective payment system, pursuant to Title XVIII of the Social Security Act, distinguishes between discharges and transfers. A discharge occurs when a patient leaves an acute-care hospital after receiving a full course of treatment. A transfer occurs when a patient is sent to another acute-care hospital for related care. An acute-care hospital receives the full diagnosis-related group (DRG) payment for a discharge and a per diem payment, not to exceed the full DRG payment, for a transfer. In response to declining costs and lengths of stay in acute-care hospitals, combined with increasing post-acute-care utilization, the BBA specified that discharges from an acute-care hospital to certain types of post-acute-care providers from any of 10 DRGs selected by the Secretary be treated as transfers. This provision became effective in Federal FY 1999. This detailed study identifies and assesses the effects of this change on payments, costs, and utilization and examines the appropriateness of expanding the policy to additional DRGs and post-acute settings.

Status: Ongoing.

99-119 **Development of a Classification System for Patients in Inpatient Rehabilitation Hospitals and Exempt Rehabilitation Units**

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|---|---|
| Project No.: | 500-97-0434/2004 |
| Period: | September 1997-April 2001 |
| Funding: | $3,842,726 |
| Award: | Task Order |
| Principal Investigator: | Ruthann Bates |
| Awardee: | Aspen Systems Corporation<br>2277 Research Boulevard<br>Rockville, MD 20850 |
| HCFA Project Officer: | J. Donald Sherwood<br>Center for Health Plans and Providers |

Description: The purpose of this task is to support HCFA in developing a classification system for patients in inpatient rehabilitation hospitals and exempt rehabilitation units of acute-care hospitals. In the original statement of work, the classification system was projected to be based on the principles of resource utilization groups methodology for patient classification that is being implemented in Medicare skilled nursing facilities. This direction has now changed. In order to meet the legislatively-mandated implementation date of October 1, 2000, HCFA has decided to award a separate contract to develop an episodic prospective payment system (PPS) for inpatient rehabilitation hospitals based on the Functional Independence Measure-Function Related Groups (FIM-FRG) methodology. To best support this effort and to develop resource and patient level information that can be used in the development and refinements of a Medicare rehabilitation hospital PPS, this is restructured to involve three major tasks:

- Conduct on-site staff time measurements and other resource use data collection in inpatient rehabilitation hospitals and exempt rehabilitation units. These data collection efforts will be conducted in two phases. First, there will be an extensive effort to collect resource use across the entire inpatient episode for a limited number of hospitals and exempt units. A second round of data collection will be conducted over a shorter time span in a larger number of hospitals and exempt units.

- C Collect patient assessments using the minimum data set for post-acute care that is being developed by the Hebrew Rehabilitation Center for the Aged under a separate contract with HCFA. These assessments will be conducted in conjunction with the on-site staff time measurements.
- C Using this information and other available sources, the project will develop analytical data files that can be used to develop and/or refine a patient classification/prospective payment system(s) for Medicare patients in rehabilitation hospitals and exempt units.

Section 4421 of the Balanced Budget Act of 1997 (P.L. 105-217) requires the Secretary to develop a PPS for inpatient rehabilitation hospitals services for Medicare patients. This PPS is to cover operating and capital costs of inpatient hospital services of a rehabilitation hospital or an exempt rehabilitation unit of an acute-care hospital and is to be implemented with cost-reporting periods beginning on or after October 1, 2000. In particular, the legislation directs the Secretary to establish classes of patients of rehabilitation facilities (each group in this subsection referred to as a case mix group), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient and a method of classifying specific patients in rehabilitation facilities within these groups. Furthermore, for each case mix group the Secretary is to assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) excluded rehabilitation hospitals from the PPS based on a diagnosis-related groups (DRG) system that was implemented in acute-care hospitals. At that time, Congress determined that the DRG system did not predict resource use in rehabilitation hospitals very well. As with other post-acute services, functional and cognitive measures are more related to rehabilitation resource use than diagnosis alone. Under TEFRA, payment for Medicare inpatient rehabilitation hospital care is based on actual cost compared to a per-case target amount that is calculated from the facility's historical cost trended forward. If the costs are less than the target amount, the hospital receives its cost plus an incentive payment. If the costs are greater than the target amount, the hospital receives its cost minus a penalty. This system does not contain any adjustments for case-mix or the intensity of services required for different patient's needs. This current system has been criticized because it seems to favor newer facilities that have historical target amounts closer to their actual costs.

In the ensuing years, attempts have been made to uniformly collect the functional information needed to develop a classification system for these facilities. Hamilton, Granger, and others developed the FIM, which is being used as a medical management tool in many rehabilitation hospitals. The FIM is designed to measure dependencies in activities of daily living, communication, and social cognition. Using the FIM, Steinman developed a patient classification system called the FIM-FRGs. These FIM-FRGs use diagnosis, FIM motor scores, FIM cognitive scores, and age to divide patients into groups based on length of stay in the rehabilitation hospital. In order to assess the feasibility of potentially using the FIM-FRG classification system as the basis for a rehabilitation prospective payment system, in 1994 HCFA contracted to:

- C Evaluate the suitability of the FIM-FRGs.
- C Develop a PPS for inpatient rehabilitation facilities.
- C Prepare final reports.

These reports used more current data to replicate previous (Steinman) work and to evaluate the feasibility of the FIM-FRG system for payment. This study found that, with limitations, the FIM-FRGs were effective predictors of resource use. FRGs based upon motor FIM scores, cognitive scores, and age remained stable over time (prediction remained consistent between 1990 and 1994). These cases were found to be as effective in predicting both the length of stay and the cost of Medicare cases as were groups defined based upon Medicare data alone. It was further found that a rehabilitation PPS was feasible. Researchers at RAND concluded that a model, based upon FIMS-FRG classifications explains approximately 50 percent of patient costs.

Status: In progress.

IM-008 **Malpractice Component of the Medicare Economic Index**

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| Funding: | Intramural |
| HCFA Project Director: | Benson L. Dutton<br>Office of Strategic Planning |

Mandate: Social Security Amendments of 1972 (P.L. 92-603)

Description: Each year since 1975, HCFA has published the Medicare Economic Index (MEI), which was first mandated by Congress in P.L. 92-603 for use in establishing reasonable charges for physician services. Since 1992, the MEI has been used as a key factor in determining the Medicare fee schedule's annual conversion factor update pursuant to Section 6102(a) of P.L. 101-239. The MEI is developed by HCFA's Office of the Chief Actuary in accordance with the basic methodology set forth in 42 Code of Federal Regulations 05.504(a)(3)(I) and 405.504(d) from selected components of the Consumer Price Index and the Producer Price Index, plus estimates of the annual changes in medical malpractice premiums for specific levels of coverage. HCFA's Office of Strategic Planning collects data from major medical malpractice insurers for calculating the annual malpractice component of the MEI. For several periods beginning January 1, 1987, the MEI increase has been established by Congress through Section 9331(c)(I) of P.L. 99-509 for fee screen year (FSY)1987, Section 4041(a) of P.L. 100-203 for the first 3 months of FSY 1988, Section 4042(b)(4)(F)(iii) for FSY 1989, and Section 4105(a) of P.L. 101-508 for FSY 1991 and FSY 1992. Again, for FSY 1994 and FSY 1995, changes in the physician fee schedule conversion factor and the Medicare volume performance standards update factor were established under Sections 13511 and 13512 of P.L. 103-66 respectively.

Status: Data for updating the medical malpractice component of the MEI have been obtained and the results were given to the Office of the Chief Actuary. Announcement of the next MEI was published in the *Federal Register* for FSY 1998 (January 1998 to December 1998).

IM-097 **Monitoring Medicare Beneficiaries' Utilization of Physician Services**

Funding: Intramural
HCFA Project Director: William J. Buczko, Ph.D.
Office of Strategic Planning

Description: This project will examine annual changes in utilization of Part B physician (and other limited license providers) utilization by Medicare beneficiaries. The data to be used are the Part B Physician Summary billing file and Part B claims for a sample panel of physicians in 36 States. The analyses planned will examine annual changes in caseload and billing, overall, by specialty, by procedure, and by selected patient characteristics. The results will be used to assess whether access to physician services has changed over time for Medicare beneficiaries.

Status: Summary billing file data are available for 1995-1997. The physician claims samples for 1996 and 1997 have been drawn and summarized. Data quality checks and comparisons with earlier analyses used for monitoring impacts of the Medicare Fee Schedule (1992-1994) are planned. If no problems are encountered, the caseload analysis will follow.

98-238 **Design and Strategy for Physician Availability in Medicare Survey**

Project No.: 500-95-0058/05
Period: September 1998-December 1999
Funding: $176,374
Award: Task Order
Principal Investigator: Jerry Cromwell, Ph.D.
Awardee: Health Economics Research, Inc.
411 Waverley Oaks Rd., Suite 330
Waltham, MA 02452-8414
HCFA Project Officer: Linda Greenberg, Ph.D.
Office of Strategic Planning

Description: HCFA needed to obtain accurate information about the extent to which physicians may currently limit services provided to Medicare Part B enrollees and the extent to which access restrictions would be affected by private contracting arrangements. This task order was to conduct a thorough review of options for surveying physicians about their willingness to provide services to Medicare beneficiaries and whether they foresee changes to their practice patterns based on private contracting arrangements. The purpose of this contract was to design a survey strategy and instruments for physicians to respond to four policy objectives:

- The willingness of physicians to treat Medicare beneficiaries.
- Possible problems with Medicare beneficiaries accessing physician services.
- Reasons for physicians restricting Medicare services.
- Reasons for physicians opting-out of Medicare and privately contracting with beneficiaries.

Specifically, HCFA wanted to obtain accurate estimates of the degree to which physician willingness to provide services to Medicare's fee-for-service population has changed in recent years, identify the factors that have contributed to any such changes, and estimate the relative importance of those factors. These surveys were called the Physician Availability in Medicare Surveys.

Status: As of December 1999, the project has been completed. In the fall of 1999, a final report of the project was submitted. The final report focused on four survey strategies and implementation plans. The report also summarized results from pilot testing the survey instruments and discussed sampling and survey bias issues.

99-045 **Study of Medicare Payments in HPSAs**

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|---|---|
| Project No.: | 500-95-0056/11 |
| Period: | September 1999-July 2001 |
| Funding: | $240,323 |
| Award: | Task Order |
| Principal Investigator: | Donna Farley |
| Awardee: | The RAND Corporation<br>1700 Main Street, P.O. Box 2138<br>Santa Monica, CA 90407-2138 |
| HCFA Project Officer: | William J. Sobaski<br>Office of Strategic Planning |

Description: Medicare includes a number of special payment provisions aimed at maintaining beneficiary access to needed services in areas where there is a scarcity of physicians and providers. These areas are designated by the Health Resources and Services Administration and are called Health Professional Shortage Areas (HPSAs). This project compiles data on trends in payment amounts, services, and recipients that have been provided by Medicare over the past decade, project future trends, and suggests and assesses alternatives to the current set of special payment provisions for HPSAs. It will review the value of all Medicare payments to HPSAs for services provided in, or to residents of, such areas. The methodology used to designate such areas is undergoing proposed changes which are expected to be finalized in the year 2000. This project will inform HCFA about the importance of several Medicare special payment policies for HPSAs and aid in the assessment of them and of alternatives.

Status: In progress.

94-008 **Collect Malpractice Insurance Premium Rate Information**

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|---|---|
| Project No.: | 500-94-0039 |
| Period: | July 1994-June 1999 |
| Funding: | $347,892 |
| Award: | Contract |
| Principal Investigator: | Theresa McMahon |
| Awardee: | Allied Technology Group, Inc.<br>1803 Research Boulevard, Suite 601<br>Rockville, MD 20850 |
| HCFA Project Officer: | Benson L. Dutton<br>Office of Strategic Planning |

Description: This project uses longitudinal hospital financial and patient discharge data available from the California Office of Statewide Health Planning and Development (OSHPD) for 1993 through 1998 to examine what factors influence individual hospital malpractice expenses. The hospital financial data reported to OSHPD provides data on malpractice costs incurred by hospitals as well as relevant utilization data, such as outpatient visits, Magnetic Resonance Imagings, and angiography among other services, and other hospital characteristics such as organizational form. When these financial data are considered in conjunction with OSHPD's patient discharge data, which would provide patient demographic information as well as a hospital case mix based on diagnosis-related groups, it should be possible to examine the role that service utilization, case-mix, and patient demographics play in hospital malpractice costs. The project undertakes an analysis of hospital-based determinants of malpractice costs as seen in longitudinal data for hospitals located in California. In addition, it plans to measure how socioeconomic factors--that is, income or perhaps education--influence hospital malpractice costs. To do this, it will match the patients' residential location found in the patients' ZIP Code to U.S. Census data. Since these demographic data are tied to the 1990 census, it may be necessary to obtain updated demographic information from an organization that tracks these changes during intra-census periods.

Status: To date the project has collected information from four State insurance commissioners' offices. Other States have either indicated that they do not collect this information or that they are "too busy" to provide responses. In the latter case, some States have indicated that the project staff could contract a local individual to come in and copy the needed files. The most common response was to list the top malpractice insurers in the

State. This listing is provided by the National Association of Insurance Commissioners and does not distinguish between physician/health professionals and institutional liability markets. The list generally reflected the insurance business for 1998.

99-126 **Collection of Malpractice Insurance Premium Data**

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|---|---|
| Project No.: | 500-97-0441/2004 |
| Period: | September 1997-September 1999 |
| Funding: | $199,819 |
| Award: | Task Order |
| Principal Investigator: | Denise Marshall |
| Awardee: | KPMG<br>1676 International Drive<br>McLean, VA 22102-4828 |
| HCFA Project Officer: | Bob Ulikowski<br>Center for Health Plans and Providers |

Description: The purpose of this project is to collect the most recent malpractice insurance premium data to complete the statutorily mandated update of the Medicare physician fee schedule geographic practice cost indices (GPCIs) and the required implementation of fee schedule resource-based malpractice relative value units (RBMRVUs). Each physician fee schedule service is by law composed of the following three components:

- Work RVUs.
- Practice Expense RVUs.
- Malpractice Insurance RVUs.

Each of these three components must be adjusted for area resource cost differences by its corresponding locality GPCI. The GPCIs must be updated every 3 years, with the next update due in 2001, and the malpractice component must be resource-based beginning in 2000. This project is a part of a larger activity to update the GPCIs and develop RBMRVUs. Specifically, this part of the project will collect malpractice insurance premium data for the most recent years available. This would preferably be 1996-98, but at a minimum would be 1996-97. At a minimum, the data must:

- Reflect premiums for at least the 20 largest physician specialties as reflected in total allowed charges in Medicare payment files.
- Represent at least 50 percent of the malpractice insurance market in each State.
- Reflect substate rating areas where such areas exist.
- Reflect mandatory patient compensation funds and joint underwriting associations where relevant.

The specialty premium data collected must be mapped to counties and Medicare localities.

Status: In progress.

IM-082 **BBA Section 4507 Opt-Out Analysis**

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| Funding: | Intramural |
| HCFA Project Director: | William J. Buczko, Ph.D.<br>Office of Strategic Planning |

Description: Section 4507 of the Balanced Budget Act of 1997 (BBA) permits physicians or practitioners to opt out of Medicare and enter into private contracts with Medicare beneficiaries. Physicians electing to opt out may not submit patient bills to Medicare for payment for a period of 2 years from the date of notifying their carrier of their desire to opt out. This project will examine the carriers' Private Contracting Data Reports and Part B Physician billing data. The data analyses will examine two issues. Descriptive and summary billing data will be obtained for physicians who have opted out of Medicare. These data will be compared to similar information for physicians still in Medicare. Summary and individual patient claim data will be used to determine the impact of physicians who have opted out on local markets for physician services (overall and by specialty) and on access to physician services for Medicare beneficiaries in these areas.

Status: The preparation of the record year update is in progress as of the end of December 1999.

99-042 **Validation of Physician Time Data**

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|---|---|
| Project No.: | 500-95-0058/07 |
| Period: | August 1999-March 2000 |
| Funding: | $214,338 |
| Award: | Task Order |
| Principal Investigator: | Nancy McCall<br>Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452 |
| HCFA Project Officer: | Jim Menas<br>Center for Health Plans and Providers |

Description: The project is focusing on the validity of the current time estimates for certain high volume codes paid under the Medicare Physician Fee Schedule. One of the tasks will be to develop alternative sets of services for validation. The project will evaluate alternative sets of criteria, including high volume, high volume per specialty, low absolute time estimates, and reference set services. It will also will construct time estimates for codes using three different secondary data sets. No primary or direct data collection will be performed under this contract. The three data sources on which analyses will be conducted are:

- The Medical Group Management's Profiling Data Base--This data base includes data on 60 physician practices in four States and includes data for 1995 and 1996. Many of the practices are large multispecialty practices.
- D. J. Sullivan Operative Time Data Base--This data base includes data from over 475 different surgical practices with 495,000 inpatient and outpatient department operative records. Surgical services are reported by common families of procedures.
- National Ambulatory Medical Care Survey (NAMCS)--This survey is conducted by the National Center for Health Statistics. The NAMCS is a national probability sample survey of visits to office-based physicians in the United States. The most recent survey collected information on office-based services furnished in 1997. This survey collects information on the physician's primary diagnosis, the time spent with the physician, and other types of diagnostic tests performed in the office.

Status: The kick-off meeting was held September 28, 1999. The project team met with HCFA staff to discuss the time validation project, including component activities and time lines for completion. A draft report of findings is due by March 1, 2000 and a final report by April 15, 2000.

99-032 **Practice Expense Methodology**

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| Project No.: | 500-95-0059/06 |
| Period: | May 1999-May 2000 |
| Funding: | $199,475 |
| Award: | Task Order |
| Principal Investigator: | Allen Dobson, Ph.D. |
| Awardee: | Lewin-VHI, Inc.<br>9302 Lee Highway, Suite 500<br>Fairfax, VA 22031-1214 |
| HCFA Project Officer: | Ken Marsalek<br>Center for Health Plans and Providers |

Description: This project provides technical assistance to evaluate various aspects of the practice expense methodology for the Medicare Physician Fee Schedule. Until January 1992, Medicare paid for physicians' services based on a reasonable charge system. This system led to payment variations among types of services, physician specialties, and geographic areas. In 1989 Congress established a fee schedule for the payment of physicians' services. Under the formula set forth in the law, the payment amount for each service is the product of three factors:

- A nationally uniform relative value.
- A geographic adjustment factor for each physician fee schedule area.
- A nationally uniform conversion factor that converts the relative value units (RVUs) into payment amounts for services.

The RVUs for each service reflect the resources involved in furnishing the three components of a physician's service:

- Physician work (i.e., a physician's own time and effort).
- Practice expenses net of malpractice expenses.
- Malpractice insurance expenses.

The original practice expense RVUs were derived from 1991 historical allowed charges. A common criticism was that for many items these RVUs were not resource-based because they were not directly based on the physician's resource inputs. HCFA was required to implement a system of resource-based practice expense relative value units (PERVUs) for all physicians' services by 1998. The Balanced Budget Act of 1997 (BBA) made a number of changes to the system for determining PERVUs, including delay of initial implementation until 1999 and provision for a 4-year transition. To obtain practice expense data at the procedure code level, HCFA convened Clinical Practice Expert Panels (CPEPs). The CPEPs provided the direct inputs of physician services, i.e., the amount of clinical and administrative staff time associated with a specific procedure, and medical equipment and medical supplies associated with a specific procedure. In June 1997, we published a proposed rule for implementing resource-based practice expense payments. The methodology incorporated elements of the CPEP process to develop the direct

expense portion of the PERVU. The indirect expense portion of the PERVU was based on an allocation formula. In addition to delaying the implementation of resource-based practice expense payments until January 1, 1999, the BBA phased in the new payments over a 4-year transition period. In developing new practice expense RVUs, we were required to:

- Utilize, to the maximum extent practicable, generally accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not just those that can be linked to specific procedures.
- Use actual data on equipment utilization and other key assumptions.
- Consult with organizations representing physicians regarding methodology and data to be used.
- Develop a refinement process to be used during each of the 4 years of the transition period.

In June 1998, we proposed a methodology for computing resource-based practice expense RVUs that uses the two significant sources of actual practice expense data we have available: CPEP data and the American Medical Association's (AMA's) Socioeconomic Monitoring System (SMS) data. This methodology is based on an assumption that current aggregate specialty practice costs are a reasonable way to establish initial estimates of relative resource costs of physicians' services across specialties. It then allocates these aggregate specialty practice costs to specific procedures and, thus, can be seen as a "top-down" approach. We used actual practice expense data by specialty to create six cost pools: administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other expenses. There were three steps in the creation of the cost pools:

- We used the AMA's SMS survey of actual cost data to determine practice expenses per hour by cost category.
- We determined the total number of physician hours, by specialty, spent treating Medicare patients.
- We then calculated the practice expense pools by specialty and by cost category by multiplying the practice expenses per hour for each category by the total physician hours.

For each specialty, we separated the six practice expense pools into two groups and used a different allocation basis for each group. For group one, which includes clinical labor, medical supplies, and medical equipment, we used the CPEP data as the allocation basis. The CPEP data for clinical labor, medical supplies, and medical equipment were used to allocate the clinical labor, medical supplies, and medical equipment cost pools, respectively. For group two, which includes administrative labor, office expenses, and all other expenses, a combination of the group one cost allocations and the physician fee schedule work RVUs were used to allocate the cost pools. For procedures performed by more than one specialty, the final procedure code allocation was a weighted average of allocations for the specialties that perform the procedure, with the weights being the frequency with which each specialty performs the procedure on Medicare patients. The BBA also requires the Secretary to develop a refinement process to be used during each of the 4 years of the period. In the 1998 notice, we finalized the proposed methodology but stated that the PERVUs would be interim throughout the transition period. Additionally, we envisioned a two-part refinement process:

- The AMA has proposed the establishment of an RVU Practice Expense Advisory Committee to review detailed, Current Procedural Terminology code level input data.
- HCFA will request contractual support for assistance on methodology issues.

This project provides that contractual support.

Status: The project staff have been concerned with the data involved in the project. They have met with HCFA and the AMA to discuss our future use of the AMA's existing SMS survey and to discuss the design and structure of its new practice-level survey. The AMA plans to conduct its survey of practices in alternating years with the SMS survey. They have completed an evaluation of the 1998 SMS questionnaire and have completed an initial review of the methodology of the practice expense per hour values derived from the SMS data. They have developed recommendations regarding the practice survey design and methodology and are considering how the practice-level survey can be used and how the information can be cross-walked to the SMS survey. In addition, they continue to meet with medical specialty organizations to review and make recommendations on data that might be of use and to hear concerns about the AMA SMS survey.

IM-080 **A Report to Congress on EPSDT Services**

Funding: Intramural
HCFA Project: Linda Greenberg, Ph.D. and

Directors: Paul W. Eggers, Ph.D.
Office of Strategic Planning

Description: This was a study of the provision of early and periodic screening, diagnosis, and treatment (EPSDT) services under Medicaid. Analyses relied on data from the State Medicaid Resource Files. The purpose of the study was to examine the actuarial value of EPSDT services.

Status: The study is completed.

IM-004 **End Stage Renal Disease Annual Research Report**

Funding: Intramural
HCFA Project Director: Paul W. Eggers, Ph.D.
Office of Strategic Planning

Description: The annual reports are designed to produce a wide range of data and analyses regarding the end stage renal disease (ESRD) program. Many of the data in these reports emphasize trends and comparisons over time, making these reports standard reference sources illustrating changes in the nature of the Medicare ESRD population and in the pattern of treatment of this population.

Status: The most recent published report is "Health Care Financing Administration: Research Report: End Stage Renal Disease, 1993-95" (HCFA Pub. No. 03393). Complimentary copies of this report are available from the Health Care Financing Administration, Office of Strategic Planning, C3-19-07, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Telephone requests can be made to (410) 786-6687.

96-079 **Medicare Competitive Bidding Demonstration for Durable Medical Equipment**

Project No.: 500-96-BPO3
Period: October 1995-August 2003
Period: Contract Modification
Principal Investigator: Elaine Myers
Awardee: Palmetto Government Benefits Administrators
P.O. Box 100190
Columbia, SC 29202
HCFA Project Officer: Mark Wynn
Center for Health Plans and Providers

Description: This demonstration project is being implemented to test the feasibility of obtaining lower prices through competitive bidding for selected lines of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The supply lines that were offered for competitive bidding at the first site are:

- Home Oxygen Therapy.
- Hospital Beds and Accessories.
- Enteral Nutrition Therapy.
- Surgical dressings.
- Urological Supplies.

Demonstrations will be implemented in two metropolitan areas. Section 4319 of the Balanced Budget Act of 1997 permits the selection of a sufficient number of suppliers in each product category to meet the projected demand at the demonstration site. Those suppliers selected as demonstration suppliers are the only ones eligible to receive Medicare payments for supplying the products covered by the demonstration to Medicare enrollees residing in Polk County, Florida. Special transitional arrangements were made for beneficiaries who had a relationship with an oxygen supplier prior to the beginning of the demonstration. In addition, current rental contracts for hospital beds and enteral pumps are allowed to complete their terms. Payments for DMEPOS products not covered by the demonstration will continue to be made at the prevailing Medicare fee schedule.

Status: The first demonstration site became operational on October 1, 1999 in Polk County. There were 73 bids from 30 suppliers for the product categories covered by the demonstration. The bids were reviewed for price and quality. Sixteen suppliers were selected as "Demonstration Suppliers" for one or more of the covered product categories. The average price reductions from the prevailing fee schedules were:

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|---|---|
| Oxygen supplies and equipment | 18% |
| Hospital beds and accessories | 30% |
| Surgical dressings | 13% |
| Enteral nutrition products | 29% |
| Urological supplies | 20% |

The new rates took effect on October 1, 1999 and will remain in effect for 2 years. A second round of bidding will take place in Polk County in 2001 to determine the prices for the final year of the project. Planning is underway to implement a second competitive bidding demonstration.

98-239 **Evaluation of Competitive Bidding Demonstration for DME and POS**

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| Project No.: | 500-95-0061/03 |
| Period: | September 1998-September 2002 |
| Funding: | $1,263,556 |
| Award: | Task Order |
| Principal Investigator: | Thomas Hoerge, Ph.D. |
| Awardee: | University of Wisconsin - Madison<br>750 University Avenue<br>Madison, WI 53706 |
| HCFA Project Officer: | Ann Meadow, Sc.D.<br>Office of Strategic Planning |

Description: HCFA has mounted a demonstration to test the feasibility and effectiveness of establishing Medicare fees for durable medical equipment (DME) and prosthetics, prosthetic devices, orthotics, and supplies (POS) through a competitive bidding process. The fundamental objective of competitive bidding is to use marketplace competition to establish market-based prices and to select DME suppliers. The Balanced Budget Act of 1997 (BBA) authorized competitive bidding demonstrations for Part B services (except physician services), and the current project is being conducted under that authority. The initial site of the demonstration is Polk County, Florida. Competitively bid product categories in Polk County include oxygen supplies and equipment, enteral nutrition, surgical dressings, urological supplies, and hospital beds. Medicare contracts with winning suppliers commenced in October 1999. Section 4319 of the BBA specifically mandates evaluation studies addressing competitive bidding impacts on expenditures, quality, access, and diversity of product selection. This task order will study these and other outcomes of the demonstration. The evaluation will use several types of research designs, such as multiple time series analysis and pre-test/post-test comparisons. The results of the evaluation will help HCFA decide how to conduct any future competitive bidding activities.

Status: Data collection activities have begun. A pre-demonstration survey of oxygen users and users of other medical supplies was fielded in two Florida counties (Polk and Brevard) in March 1999. The results suggested that beneficiaries were highly satisfied with the services and products delivered by their Medicare suppliers. A follow-up survey is to be conducted during calendar year (CY) 2000. Two site visits in 1999 were conducted as part of the evaluation's case study activities, focusing on administrative and market outcomes. Other evaluation activities now in the planning stages include claims analyses, focus groups, fee-schedule analyses, and additional surveys. The first annual evaluation report is scheduled for release in early CY 2001.

98-256 **Medicare Competitive Bidding Demonstration**

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|---|---|
| Project No.: | 500-95-0061/02 |
| Period: | September 1998-September 2000 |
| Funding: | $883,568 |
| Award: | Task Order |
| Principal Investigator: | Sarita Karon |
| Awardee: | University of Wisconsin - Madison<br>750 University Avenue<br>Madison, WI 53706 |
| HCFA Project Officer: | Victor G. McVicker<br>Center for Health Plans and Providers |

Description: Under the Balanced Budget Act of 1997, Congress authorized the Secretary of Health and Human Services to implement up to five demonstration projects of competitive bidding for Part B items and services, except physician services. Each demonstration project may be conducted in up to three competitive acquisition areas for a 3-year period and must be terminated by December 31, 2002. Under this task order, the University of Wisconsin (subcontractors are the Research Triangle Institute and Northwestern University) provides support in the implementation and operation of the clinical lab competitive bidding demonstration. This task also will provide additional support in evaluating and developing models for bidding of Part B services other than physician services, lab services, and durable medical equipment. Furthermore, the contractor will gather data and write a report on the prices charged by suppliers and the amounts paid by other buyers for Part B items.

Status: HCFA held a kickoff meeting with the contractor on October 14, 1998. During the first year of the project, the contractor will be completing the following deliverables:

Clinical laboratory demonstration:
- C Site selection paper.
- C Revised demonstration design.
- C Pre-solicitation report for each site.

Other Part B services:
- C Recommendation paper for selecting other Part B services for bidding.

C Design options paper.
C Final design report.

There has been substantial controversy regarding these demonstrations and Congress has delayed their implementation until 2002.

99-120 **Study of the Current Medicare Payment Methodology for Clinical Laboratory Tests**

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| Project No.: | 500-99-0023 |
| Period: | July 1999-September 2000 |
| Funding: | $862,508 |
| Award: | |
| Principal Investigator: | Janet Corrigan, Ph.D. |
| Awardee: | National Academy of Sciences<br>Institute of Medicine<br>2101 Constitution Ave, NW.<br>Washington, DC 20418 |
| HCFA Project Officer: | Anita Greenberg<br>Center for Health Plans and Providers |

Description: The project is directed by Section 4553 of the Balanced Budget Act of 1997 (P.L. 105-33). The legislation specified that the Secretary request the Institute of Medicine (IOM) of the National Academy of Sciences to study the current Medicare payment methodology for clinical laboratory tests. The study will encompass adequate reimbursement, access, and quality and recommend alternate payment methodologies. Upon completion of the study, the Secretary must report the results to Congress. The current legislation provides a payment methodology for laboratory tests that is inflexible to changes in technology, correction of base year fees (i.e., Pap smears), and competitive market prices for high volume laboratory tests. A detailed study is necessary to identify the legislative and administrative changes that could direct reimbursement to the most effective and efficient laboratory testing for Medicare beneficiaries. The project will document significant differences between today's laboratory industry versus the laboratory industry in 1984, when the clinical laboratory fee schedule was enacted. Reimbursement, access, and quality of laboratory testing will be addressed separately. It will also assess the strengths and weaknesses of the current Medicare payment methodology for laboratory tests. Literature reviews, interviews, and research of legislative history will be included. It will investigate and obtain nongovernmental sources of costs of performing laboratory tests including: Pap smears, prostate cancer assays, HIV viral load testing, cancer markers, complete blood counts, and molecular diagnostic testing. It will provide tables to help evaluate the impacts of laboratory size, specialty, site of service, and geographic location on the costs of performing laboratory tests. Finally, it will recommend alternative Medicare payment methodologies for laboratory tests.

Status: The 3-month status teleconference call was held on September 23, 1999. IOM has realigned its staff to support the study and hired a study director. Selecting the evaluation committee members for the study was nearly completed. On October 27, 1999, the study director traveled to HCFA Central Office and met with HCFA staff throughout the day to assemble historical and current information on the Medicare clinical laboratory fee schedule. The 6-month teleconference was held on December 16, 1999. The first of five open-to-the-public panel meetings is scheduled for January 20-21, 2000 in Washington, D.C. The second meeting is scheduled for March 13-14. Details of these meetings are under development.

**NURSING HOME CASE-MIX AND QUALITY DEMONSTRATION**

Description: The Nursing Home Case-Mix and Quality Demonstration builds on past and current initiatives to develop an improved nursing home case-mix payment and quality assurance system for the Medicare and Medicaid programs. This demonstration designed and implemented a Medicare nursing home resident classification and payment system in Texas and New York. Four other States--South Dakota, Mississippi, Maine, and Kansas--implemented a combined Medicare and Medicaid system. The purpose of the demonstration is to test a resident information system with variables for classifying residents into homogeneous resource use groups for equitable payment and for quality monitoring of outcomes adjusted for case mix. The Minimum Data Set plus (MDS+) for resident assessment is used for resident-care planning, payment classification, and quality-monitoring systems. The project has consisted of three phases: systems development and design, systems implementation and monitoring, and evaluation.

Status: The project conducted a field test of the minimum data set on 6,660 nursing home residents. The resident classification system and a Multistate Medicare/Medicaid Payment Index containing 44 groups was created. A 35-group variation was approved in January 1993 for the

Medicaid portion in Mississippi and South Dakota. The variation collapses the 12 rehabilitation groups into three groups for Medicaid purposes. The States collected and reviewed over 4 million MDS+ documents on over 600,000 different residents assessed between September 1990 and July 1997. In developing the payment systems, the resident characteristic data and facility cost reports have been analyzed to determine the case mix of residents and patterns of service utilization. The Medicare case-mix-adjusted payment system was implemented in early 1996. The quality-monitoring information system has been tested, and 30 quality indicators are being used for monitoring facility-level and resident-level quality. In 1995, a second staff-time study was completed on Medicare portions of skilled nursing facilities using the national MDS2.0. The resource utilization groups, version III classification and index were updated and became effective in January 1997 for the Medicare portion of the demonstration. Prospective rates for rehabilitation services were added for Medicare. A third time study was done on Medicare units in nondemonstration States in 1997 to validate the 1995 study findings. The 1995 and 1997 time study data will be combined for use in the first year of the national system.

The Balanced Budget Act of 1997 established a national skilled nursing facility prospective payment system based on the experience from this demonstration and others. Facilities in the Medicare portion of this demonstration will transition to the national system at the beginning of their individual fiscal year beginning after June 30, 1998.

89-054 **Multistate Nursing Home Case-Mix and Quality Demonstration: Kansas**

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| Project No.: | 11-C-99366/7 |
| Period: | June 1989-March 1999 |
| Funding: | $1,544,755 |
| Period: | Cooperative Agreement |
| Principal Investigator: | Elaine Wells |
| Awardee: | Kansas Department of Social and Rehabilitative Services<br>West Hall<br>300 Oakey Street, SW.<br>Topeka, KS 66606 |
| HCFA Project Officer: | Catherine Jansto<br>Center for Health Plans and Providers |

89-055 **Multistate Nursing Home Case-Mix and Quality Demonstration: Maine**

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|---|---|
| Project No.: | 11-C-99363/1 |
| Period: | June 1989-March 1999 |
| Funding: | $1,290,838 |
| Period: | Cooperative Agreement |
| Principal Investigator: | Andrew Coburn, Ph.D. |
| Awardee: | Maine Department of Human Services<br>State House Station No. 11<br>Augusta, ME 04333 |
| HCFA Project Officer: | Catherine Jansto<br>Center for Health Plans and Providers |

89-056 **Multistate Nursing Home Case-Mix and Quality Demonstration: Mississippi**

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|---|---|
| Project No.: | 11-C-99362/4 |
| Period: | June 1989-March 1999 |
| Funding: | $1,572,289 |
| Period: | Cooperative Agreement |
| Principal Investigator: | Jamie L. Collier |
| Awardee: | Office of Governor<br>Robert E. Lee Building, Suite 801<br>Jackson, MS 39201 |
| HCFA Project Officer: | Catherine Jansto<br>Center for Health Plans and Providers |

90-019 **New York Case-Mix Payment and Quality Demonstration**

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|---|---|
| Project No.: | 95-C-99540/2 |
| Period: | May 1990-June 1999 |
| Funding: | $981,718 |
| Period: | Cooperative Agreement |
| Principal Investigator: | Robert W. Barnett |
| Awardee: | New York State Department of Health<br>Empire State Plaza<br>Room 1683 Corning Tower<br>Albany, NY 12237 |
| HCFA Project Officer: | Catherine Jansto<br>Center for Health Plans and Providers |

89-057 **Multistate Nursing Home Case-Mix and Quality Demonstration: South Dakota**

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|---|---|
| Project No.: | 11-C-99367/8 |
| Period: | June 1989-March 1999 |
| Funding: | $1,320,290 |

Period: Cooperative Agreement
Principal Investigator: Carol Job, R.N.
Awardee: South Dakota Department of Health
700 Governors' Drive
Pierre, SD 57501
HCFA Project Officer: Catherine Jansto
Center for Health Plans and Providers

89-058 **Multistate Nursing Home Case-Mix and Quality Demonstration: South Dakota**

Project No.: 95-C-99364/8
Period: February 1992-March 1999
Funding: $1,570,296
Period: Cooperative Agreement
Principal Investigator: Donna Yuill
Awardee: South Dakota Department of Health
Office of Rural Health
700 Governors' Drive
Pierre, SD 57501
HCFA Project Officer: Catherine Jansto
Center for Health Plans and Providers

92-028 **Texas Medicare Nursing Home Case-Mix and Quality Demonstration**

Project No.: 95-C-90019/6
Period: February 1992-March 1999
Funding: $307,382
Period: Cooperative Agreement
Principal Investigator: Stephen A. Lorenzen, Ph.D.
Awardee: Texas Department of Human Services
Office of Strategic Management,
Research and Development
P.O. Box 149030 (MC-E-601)
Austin, TX 78714-9030
HCFA Project Officer: Catherine Jansto
Center for Health Plans and Providers

92-211 **Multistate Nursing Home Case-Mix and Quality Demonstration: Texas**

Project No.: 95-C-99131/6
Period: February 1992-March 1999
Funding: $859,268
Award: Cooperative Agreement
Principal Investigator: Stephen A. Lorenzen, Ph.D.
Awardee: Texas Department of Human Services
Office of Strategic Management,
Research and Development
P.O. Box 149030 (MC-E-601)
Austin, TX 78714-9030
HCFA Project Officer: Catherine Jansto
Center for Health Plans and Providers

94-081 **Evaluation of the Nursing Home Case-Mix and Quality Demonstration**

Project No.: 500-94-0061
Period: September 1994-December 1999
Funding: $2,980,219
Period: Contract
Principal Investigator: Robert J. Schmitz, Ph.D.
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: Edgar A. Peden, Ph.D.
Office of Strategic Planning

Description: Using data from the Nursing Home Case-Mix and Quality (NHCMQ) Demonstration, HCFA is evaluating the new practice of paying skilled nursing facilities (SNF) for Medicare skilled nursing services on a prospective basis. Prior to July 1, 1998, SNFs were reimbursed on a retrospective basis for their reasonable costs. Since that date, however, following methods used in the NHCMQ demonstration, a new prospective methodology has been implemented. Under this methodology, patients are classified into resource utilization groups which are then used to calculate each facility's case mix. HCFA then pays facilities for each covered day of care, according to the case mix of patients residing there on any given day. Though some costs will continue to be paid on a retrospective cost basis under the demonstration, the prospective rate will eventually include inpatient routine nursing costs and therapy costs. To guard against the possibility that inadequate care would be provided to patients with heavy care needs, a system of quality indicators has been developed that will be used to monitor the quality of care. The demonstration project that led to the current program was implemented in six States (Kansas, Maine, Mississippi, New York, South Dakota, and Texas) in the summer of 1995, with Medicare-certified facilities in these States being offered the opportunity to participate on a voluntary basis. The evaluation of this demonstration project seeks to estimate specific behavioral responses to the introduction of prospective payment and to test hypotheses about certain aspects of these responses. The principal goal of the

evaluation of the NHCMQ Demonstration is the estimation of the effects of case-mix-adjusted prospective payment on the health and functioning of nursing home residents, their length of stay, and use of health care services; the behavior of nursing facilities; and the level and composition of Medicare expenditures.

Status: Interim analyses of admitting patterns and select outcomes have been undertaken, and visits to demonstration and nondemonstration facilities have been completed which should help in understanding provider response to the payment demonstration. Data base construction and analysis of the third phase of the demonstration, which bundled skilled therapy services into the prospectively-paid routine rate has been completed. This primary data collection activity was completed in July 1999. MDS assessments were matched to Medicare SNF and hospital claims and to HCFA Provider-of-Service records to create the analytic data base for the project. Current analytic activities center around assessing and revising the draft final report. Of special interest is the analysis of primary data regarding the provision of professional therapy services in both demonstration sites and comparison sites.

99-057 **Evaluation of Issues Related to PPS under Consolidated Bidding for SNFs and HHAs**

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| Project No.: | 500-96-0026/14 |
| Period: | August 1999-April 2000 |
| Funding: | $390,192 |
| Award: | Task Order |
| Principal Investigators: | Jerry Kowlaczyk and Sam McNeill |
| Awardee: | Jing Xing Health and Safety Resources, Inc. P.O. Box 6655, 1312 Vincent Pl. McLean, VA 22106-6655 |
| HCFA Project Officer: | Gertrude Saunders Center for Health Plans and Providers |

Description: HCFA is interested in learning more about the claims processing and medical review issues that will be caused by consolidated billing for skilled nursing facility (SNF) services and by using a prospective payment system (PPS) for SNF services. Section 4432 of the Balanced Budget Act of 1997 (BBA) requires consolidated billing and PPS for SNFs. Under the consolidated billing requirement, a SNF must submit all Medicare claims for all the services its residents receive (except for certain excluded services specified in the legislation). SNFs will no longer be able to "unbundle" services (have them provided by outside suppliers that can then submit a separate bill directly to the Part B carrier). As a result, outside suppliers must look to the SNF for payment. Both Part A intermediaries and Part B carriers are currently involved in SNF payments, and HCFA decided these consolidated claims must be submitted to the Part A intermediary. This generated controversy within the supplier community about whether Part A intermediaries or the specialized Part B carriers--Durable Medical Equipment Regional Carriers (DMERCs)--are in a better position to process such claims. Both Part A and Part B services are included in this analysis. In Part B, the focus is on services by durable medical equipment (DME) providers, therapists, labs, and other diagnostic services. Both individual providers and institutional providers could be involved. Section 4603 of the BBA requires consolidated billing and PPS for Home Health Agencies (HHAs). Thus, this study will also include a similar analysis of consolidated billing by HHAs to Regional Home Health Intermediaries. This is particularly related to DME billing in home service settings. This study will not address the established reimbursement rates or rate setting methodologies. The project will examine:

- The problems the planned operations policy will have on providers, fiscal intermediaries, Part B carriers, and the DMERCS.
- What billing practices of providers for services will be affected by SNF/HHA consolidated billing and PPS.
- The current practices with respect to what entity provides for what types of services.
- The optimum process/flow for medical review for items formerly billed to the DMERC but which must now be billed to the fiscal intermediary (and what changes in procedures would be needed to achieve the optimum process/flow).

Status: The data have been analyzed for one State and the report is in preparation.

96-078 **RUG III Validation for National Skilled Nursing Facility Payment System**

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| Project No.: | 500-96-0027 |
| Period: | September 1996-March 1999 |
| Funding: | $841,197 |
| Period: | Contract |
| Principal Investigator: | Robert E. Burke, Ph.D. |

Awardee: Allied Technology Group, Inc.
1803 Research Boulevard, Suite 601
Rockville, MD 20850
HCFA Project Officer: Carolyn Rimes
Center for Health Plans and Providers

Description: This project examines and reports on the differences and similarities in practice patterns across the States. The study does this by conducting additional staff time measurement studies in skilled nursing facilities (SNF) in States identified as providing more than the average level of rehabilitation services in Medicare units, and in units identified as "subacute" Medicare providers. The study is being conducted in California, Colorado, Florida, and Maryland. A stratified sample of freestanding and hospital-based facilities is used and includes units in both settings that are identified as subacute by a technical expert panel representing the SNF industry, therapists, and other experts from the research community.

Status: The data collection phase started in the fall of 1997. This information, combined with the information from a similar staff-time measurement conducted in 1995, formed the basis for the case-mix index for the national SNF prospective payment system.

97-214 **Refining Resource Utilization Groups for a National Skilled Nursing Facility System**

Project No.: 500-96-0003/05
Period: September 1997-December 1999
Funding: $238,917
Award: Task Order
Principal Investigator: Alan White
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: J. Donald Sherwood
Center for Health Plans and Providers

Description: The purpose of this contract is to examine and report on possible refinements to the resource utilization groups, version III (RUG III) methodology for classification of skilled nursing facilities' (SNF) residents based on their predicted resource consumption. This study will examine the components of another resident classification system, the Nursing Severity Index (NSI), and determine if items contained in the NSI could improve the predictability of the RUG III system. The study will be conducted using existing resident-level information and facility resource use data from a sample of SNFs in 12 States.

Status: The project's technical evaluation panel met and provided comments on a preliminary draft report. The final report has been completed.

98-250 **Variations in Prescribed Medication Costs, Methods of Collections and Impact on Case Mix for Skilled Nursing Facilities**

Project No.: 500-96-0003/07
Period: September 1998-September 2000
Funding: $814,428
Award: Task Order
Principal Investigator: Terry Moore
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officers: J. Donald Sherwood
Center for Health Plans and Providers
Carolyn Rimes
Center for Health Plans and Providers

Description: This task order will help HCFA determine the impact of specific ancillary services, e.g., supplies and equipment (concentrating on prescribed medications), on resource utilization groups (RUG). This project seeks to determine the impact, if any, on the RUGs classification system including concentrated analysis on the residents requiring high medical care, payments and patient's diagnoses, and will provide insight to the medical outcome. The RUG methodology has been successful in identifying patient characteristics that relate to variation in patients' need for resources, e.g., nursing and rehabilitation services. However, this methodology has not, to date, included selected ancillary services (supplies and equipment, specifically prescribed medication).

Status: This project is constructing a database, including the Systematic Assessment of Geriatric Drug Use via Epidemiology with the Minimum Data Set, Online Survey Certification and Reporting system and other HCFA administrative data. Following database analysis, the project will analyze these data to assess alternative approaches for potential refinement of the RUG-III system.

98-251 **Measurement, Indicators, and Improvement of the Quality of Life in Nursing Homes**

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| Project No.: | 500-96-0008/05 |
| Period: | June 1998-November 2000 |
| Funding: | $1,853,183 |
| Award: | Task Order |
| Principal Investigator: | Rosalie Kane |
| Awardee: | University of Minnesota<br>420 Delaware Street, SE.<br>Minneapolis, MN 55455-0392 |
| HCFA Project Officer: | Mary Pratt<br>Office of Clinical Standards and Quality |

Description: This task order will design an evaluation that gives additional knowledge and tools to contribute to the improvement of quality of life (QoL) for nursing home residents. It will focus on three topics:

- Measuring and developing indicators of QoL.
- Developing quality improvement programs for nursing home QoL.
- Evaluating environmental design influences on QoL.

There will be an independent assessment of QoL at 40 nursing homes to provide an objective standard of QoL measurement. The contractor will also test techniques for diagnosis of QoL problem areas and provide technical assistance to the homes to improve the QoL.

Status: The major areas of focus include development of QoL instruments (identification and definition of possible domains), preparation of facility-level sampling design, and research into quality improvement programs. Field work began in November 1999, starting in the States of Minnesota and Florida.

99-027 **Home Health Prospective Payment System Baseline Audit Sample Analysis and Adjustment**

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|---|---|
| Project No.: | 500-96-0026/12 |
| Period: | January 1999-May 1999 |
| Funding: | $32,442 |
| Award: | Task Order |
| Principal Investigator: | Cliff Bailey |
| Awardee: | Jing Xing Health and Safety Resources, Inc.<br>P.O. Box 6655, 1312 Vincent Pl.<br>McLean, VA 22106-6655 |
| HCFA Project Officer: | Randy Throndset<br>Center for Health Plans and Providers |

Description: In February of 1988, HCFA directed its fiscal intermediaries (FI) to conduct comprehensive audits of the cost reports submitted by a sample of home health agencies whose cost reporting periods ended in Federal fiscal year 1997. The purpose of these audits was to provide a representative body of audited cost report data required by the Balanced Budget Act of 1997 for the development of a home health prospective payment system. Each FI received a list of agencies to audit and instructions on how to conduct the audits and report the data obtained. The sample was designed so that it would include variables representative of the home health industry, including:

- Provider type.
- Census region.
- Urban versus rural location.
- Large versus small agencies.

Since it was anticipated that a significant number of agencies in the sample could not be audited because their records were unavailable or their cost reporting periods were less than 12 months long, the sample size was adjusted upward by 15-20 percent. In practice, over 15 percent of the providers (approximately 100 providers of the 645 provider numbers selected) could not be audited for various reasons. Thus, it was unclear whether the nonrespondents were spread uniformly across the sample strata or concentrated in particular ones. The pattern and extent of nonresponse critically affects how the data are used. This project was concerned with nonresponse adjustment of the sample data so they could be used, in part, in the development of national home health prospective payment system rates. Since the exact payment categories have not been devised, several analytical approaches were checked to facilitate choosing the most appropriate method to adjust the data. Specifically, the project conducted nonresponse analysis and modeling of the data. This involved comparing the list of home health agencies actually audited with the original sample list to (1) compare the actual standard error achieved with the design specification of 5 percent standard error, and (2) determine the bias, if any. It developed several alternative methods to adjust the sample data for the observed patterns of nonresponse and evaluated the merits and liabilities of each approach. This involved:

- Nonresponse modeling.
- Post-sample stratification.
- Creation of observation-specific weights.

Status: The project is completed.

96-057 **Case-Mix Adjustment for a National Home Health Prospective Payment System**

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|---|---|
| Project No.: | 500-96-0003/02 |
| Period: | July 1996-September 2000 |
| Funding: | $3,416,094 |
| Award: | Task Order |
| Principal Investigator: | Henry Goldberg |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officer: | Ann Meadow, Sc.D.<br>Office of Strategic Planning |

Description: The primary focus of this study is to understand existing variation in home health resource patterns and to use this information to develop a case-mix adjustment system for a national home health prospective payment system (PPS). In this study, the Outcomes and Assessment Information Set (OASIS), which has been developed for outcome-based quality assurance and improvement for Medicare home health agencies, is being examined to see whether items included in this instrument will be useful for case-mix adjustment. Detailed information, including information on resource utilization and additional items needed for case-mix adjustment not included on OASIS, has been collected from participating agencies.

Status: Ninety agencies were recruited and trained from eight States in the spring and summer of 1997. All agencies began data collection on a 6-month cohort of new admissions to home care beginning in October 1997. Data collection ended in the spring of 1999. Analysis to date has resulted in a viable, clinically coherent system of 80 case-mix groups that explains more than 30 percent of the variation in resource use on a development sample drawn from the cohort members. Resource use is measured for 60-day periods of care, to conform to the planned unit of payment under the forthcoming national PPS. Selected OASIS assessment items, collected at the start of care, are used in the grouping system. The case-mix items fall into three major domains: clinical factors, functional-status factors, and utilization factors. Within each domain, a parsimonious set of items is summarized into a score for the patient. In two of the domains, scores are partitioned into four levels corresponding to high, moderate, low, and minimal impact, based on the relationship of the score to resource utilization. In the third domain, scores are partitioned into five impact levels. A patient's combination of levels on all three domains identifies the group into which the patient is classified for purposes of case-mix adjusting the prospective payment amount. Under this system, the patient's case mix classification is updated at the end of the payment period to reflect the actual amount of home therapy services received during the 60-day payment period. This information is necessary to arrive at a final score for the utilization domain.

Results of the study to date are described in two reports:

- *Case-Mix Adjustment for a National Home Health Prospective Payment System: First Interim Report*, July 1998 (revised December 1998).
- *Case-Mix Adjustment for a National Home Health Prospective Payment System: Second Interim Report*, September 24, 1999.

A third final report covering further validation results is expected early in 2000.

94-087 **Maximizing the Cost Effectiveness of Home Health Care: The Influence of Service Volume and Integration with Other Care Settings on Patient Outcomes**

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| Project No.: | 17-C-90435/8 |
| Period: | September 1994-December 2000 |
| Funding: | $1,496,245 |
| Award: | Cooperative Agreement |
| Principal Investigator: | Robert Schlenker, Ph.D. |
| Awardee: | Center for Health Policy Research<br>1355 S. Colorado Boulevard, Suite 706<br>Denver, CO 80222 |
| HCFA Project Officer: | Ann Meadow, Sc.D.<br>Office of Strategic Planning |

Description: Home health care (HHC) is the most rapidly growing component of the Medicare budget in recent years. The rapid growth in home health use has occurred despite limited evidence about the necessary volume of HHC to achieve optimal patient outcomes and whether it substitutes for more costly institutional care. Little is known about integrating HHC with care in other settings to reduce overall health care costs. The central

hypotheses of this study are that volume-outcome relationships are present in HHC for common patient conditions, that upper and lower volume thresholds exist that define the range of services most beneficial to patients, and that a strengthened physician role and better integration of HHC with other services during an episode of care can optimize patient outcomes while controlling costs. To test these hypotheses, a sample of 3,600 patient records is being analyzed from agencies in 20 States stratified into high, medium, and low-volume categories based on annual visits per beneficiary. Trained data collectors at each agency recorded patient health status and service information between HHC admission and discharge to assess patient outcomes and costs within the HHC episode. Long-term, self-reported outcomes are being measured from telephone interview data at HHC admission and from 6-month follow ups. These primary data concerning patient status and outcomes will be combined with Medicare claims data over the episode of care to study the relationship between service volume in HHC and both patient outcomes and costs.

Status: Study Paper 1, Research Design Update, which summarized the research design and its evolution from the original proposal, was finalized in September 1998. Primary data collection ended in late 1998. An interim report on a subsample of 1,000 patients (February 1999) described case mix and volume relationships. Separately for the four common conditions (congestive heart failure, stroke, surgical hip procedures, and open wounds), a high- and low-volume group was selected by taking the highest and lowest 45 percent of the arrayed cases within each condition. Two sample tests for mean differences in case mix characteristics and volume were performed to compare the two volume groups within each condition. The median volume (defined as number of visits until discharge or first inpatient admission) differed by a factor of about four to nine, depending on the condition. For home health aide services, mean volume differed by a factor of between 30 and 47. Many case mix indicators were measured at the start of care. Of these, few demographic indicators differed between the volume groups within condition. But limitations in activities of daily living were significantly greater for the high-volume groups. These patients had a greater prevalence of chronic conditions, and their institutional utilization within the 14 days prior to admission was less likely to be an acute-care hospital, indicating the more post-acute nature of the low-volume groups. This general case mix difference is consistent with the greater use of aide services for high-volume patients. Preliminary analyses of outcomes suggested relatively few differences in outcomes by volume. This result may mean that the additional services delivered to the high-volume group helped equalize outcomes between more severely ill and less severely ill patients. Risk-adjusted analyses planned for later in the study are necessary to further explore this possibility.

94-074 **Design and Implementation of Medicare Home Health Quality Assurance Demonstration**

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|---|---|
| Project No.: | 500-94-0054 |
| Period: | September 1994-September 2000 |
| Funding: | $4,340,309 |
| Award: | Contract |
| Principal Investigator: | Peter W. Shaughnessy, Ph.D. |
| Awardee: | Center for Health Policy Research<br>1355 S. Colorado Boulevard, Suite 706<br>Denver, CO 80222 |
| HCFA Project Officer: | Armen H. Thoumaian, Ph.D.<br>Office of Clinical Standards and Quality |

Description: Currently, Medicare's home health survey and certification process is primarily focused on structural measures of quality. Although this process provides important information about home health care, an approach based on patient outcome measures would substantially increase the Medicare program's capacity to assess and improve patient well-being. To address this need, the Medicare Home Health Quality Assurance Demonstration will test an approach to develop outcome-oriented quality assurance and promote continuous quality improvement in home health agencies (HHA).

The demonstration was implemented through a contract with the Center for Health Policy Research (CHPR), University of Colorado, to determine the feasibility of and establish the methodology for a national approach for outcome-based quality improvement (OBQI). Outcome measures are computed using the Outcomes and Assessment Information Set (OASIS), a set of valid, reliable measures, developed through research efforts conducted for HCFA by CHPR (1988-1994) to assess patient outcomes of care provided in the home.

Under the demonstration, staff of 50 regionally-dispersed HHAs complete the OASIS data collection instrument for each patient at the start of care and at 60-day intervals (up to and including discharge). The OASIS data are submitted monthly to CHPR for validation and storage.

There are three rounds of data analysis and outcome report generation, each based on 12 months of data.

The general framework for OBQI is a two-stage process of continuous quality improvement. Data are collected at regular time intervals for all adult patients. Risk adjustment is undertaken and outcome reports are produced for specific patient conditions ("focused reports") and for all adult patients ("global reports"). These reports are provided to the participating HHAs and are used to determine which outcomes are inferior, thereby providing a focus for agency staff to target problematic care. Exemplary care is also investigated in order to reinforce positive care behaviors. A plan of action allows the agency to monitor the changes in care behavior and through the next round of data collection, determine if targeted outcomes have improved and if reinforcement activities have maintained exemplary outcomes.

Status: Fifty agencies in 26 States were phased into the demonstration beginning in January 1996. In January 1997, the demonstration agencies received their first outcome reports and developed plans of actions to improve care for two patient outcomes during 1997. Agencies received their second annual reports in May 1998, which contained baseline comparisons from 1997, and received their third and final reports in May 1999. The original contract was modified to provide assistance in the nationwide implementation of OASIS collection and reporting, with funding increased to a total of $4,340,000. A final report on the evaluation of the demonstration effort is expected by the summer of 2000.

95-076 **Phase II Implementation of the Home Health Agency Prospective Payment Demonstration**

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|---|---|
| Project No.: | 500-95-0011 |
| Period: | September 1995-September 1999 |
| Funding: | $1,811,184 |
| Award: | Contract |
| Principal Investigator: | Henry Goldberg |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officer: | J. Donald Sherwood<br>Center for Health Plans and Providers |

Description: This contract implements and monitors Phase II of the Home Health Agency (HHA) Prospective Payment Demonstration. Under Phase II, a single payment-per-episode approach is being tested for Medicare-covered home health care. HHA participation is voluntary. Approximately 90 agencies in California, Florida, Illinois, Massachusetts, and Texas participate in the demonstration. HHAs that agree to participate were randomly assigned to either the prospective payment method or a control group that continues to be reimbursed in accordance with the current Medicare retrospective cost system. HHAs participate in the demonstration for 3 years.

Status: Phase II recruitment began in the fall of 1994 under a previous contract with Abt Associates, Inc. The HHAs entered into the demonstration at the beginning of their fiscal years. Several HHAs began receiving per-episode payments in June 1994, with the majority entering the demonstration in January 1996. The episodic payment rates are prospectively set for each HHA, reflecting its previous practice and cost experience. Rates are adjusted annually. As a protection to both the HHAs and the Medicare program, there are retrospective adjustments for sharing of gains or losses and for changes in an HHA's projected case mix. The project was extended and ran through 1999.

94-082 **Evaluation of Phase II of the Home Health Agency Prospective Payment Demonstration**

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| Project No.: | 500-94-0062 |
| Period: | September 1994-June 2000 |
| Funding: | $3,528,408 |
| Award: | Contract |
| Principal Investigator: | Barbara Phillips, Ph.D. |
| Awardee: | Mathematica Policy Research, Inc.<br>P.O. Box 2393<br>Princeton, NJ 08543-2393 |
| HCFA Project Officer: | Ann Meadow, Sc.D.<br>Office of Strategic Planning |

Description: This contract is evaluating Phase II of the Home Health Agency (HHA) Prospective Payment Demonstration, under which HHAs are paid on a prospective basis for an episode of care reimbursed by the Medicare program. (Phase I tested per-visit prospective payment for HHAs.) Ninety-one agencies from five sites--California, Florida, Illinois, Massachusetts, and Texas--were randomly assigned to either the treatment group (prospective payment system (PPS) method, 48 agencies) or the control group (conventional cost-based reimbursement, 43 agencies). The agencies phased into the demonstration at the

beginning of their 1996 fiscal year. Treatment-group agencies can reduce the cost of care they provide during a 120-day payment period by reducing visits, changing the mix of visits to make less costly visits a larger proportion of visits, reducing per-visit costs, or some combination of all three. The cost-reducing activities raise the possibility that quality of care might deteriorate under episode-based payment. Quality impacts, along with cost, utilization, and qualitative, behavioral effects, are the focus of the evaluation. The findings will indicate not only the overall effects of the change in payment methodology, but also how the effects are likely to vary with the characteristics of agencies and patients.

Status: Interim findings from the evaluation, based primarily on the first 8 to 15 months of demonstration operations, are described in following documents:

- *Transition Within a Turbulent System: An Analysis of the Initial Implementation of the Per-Episode Home Health Prospective Payment Demonstration*, August 6, 1997.
- *Preliminary Report: The Impact of Prospective Payment on Medicare Home Health Quality of Care*, January 30, 1998.
- *Preliminary Report: The Impact of Prospective Payment on Medicare Home Health Use--Promising Results for a Future Program*, July 22, 1998.
- *The Impact of Prospective Payment on Medicare Service Use and Reimbursement During the First Demonstration Year*, December 1998.
- *Preliminary Report: The Impact of Prospective Payment on the Cost per Episode: Striking the Balance Between Decreasing Use and Increasing Cost*, July 22, 1999.

Findings from the first 2 years of the evaluation are described in additional reports forthcoming in calendar year 2000. Findings from the interim analysis of cost impacts suggest that, on average, prospective payment reduced the cost of care during the 120-day episode period by $419 or 13 percent. The impact on cost was similar across different types of agencies, except that small agencies (less than 30,000 visits in year before the demonstration) exhibited a significantly smaller effect than large agencies. Findings from the utilization study suggest that the per-episode group of HHAs was able to reduce the number of visits provided during the 120-day episode period by 17 percent and the time from admission to discharge by 15 percent. The proportion of patients receiving care in each home health discipline changed little under episode payment. The utilization findings generally applied to agencies regardless of size, nonprofit status, affiliation status (hospital or freestanding), or use pattern (i.e., whether the agency provided more or less than the average number of visits during a base year, given its case mix).

The reduction in visits has not led to compensating utilization in other parts of the health care system. An analysis of utilization and reimbursement for Medicare-covered services other than home health found that prospective payment did not affect the use of or reimbursement for such services during the 120-day episode period. An investigation of spillover effects in settings not covered by Medicare similarly found no compensating utilization. For example, prospective payment did not affect the likelihood of receiving nonresidential services such as personal care aides and adult day care, based on results from a patient survey. These findings suggest that a reduction in home health utilization at the level observed under the demonstration does not adversely affect care quality or shift costs to services in other settings. Other interim analyses of quality impacts found few differences in patient outcomes between treatment and control agencies, and when differences were found, they were small. Analysis of claims data indicated that PPS patients have significantly lower emergency room use. There were no significant differences due to PPS in any other outcomes studied from the claims data, including institutional admissions for a diagnosis related to the home health care and mortality. Results from the first patient survey on client satisfaction suggested that both treatment and control group clients were generally satisfied. On three specific components of satisfaction with agency staff, treatment-group clients were found to be somewhat less satisfied than control group clients, although satisfaction levels were quite high in both groups. Measures of health and functional outcomes from the survey offered equivocal evidence for small negative effects of prospective payment in a few of the functional outcomes. These results are preliminary and require further study in a planned follow-up survey. Half of the treatment agencies selected for case study early in the demonstration reported plans for specific initiatives to reduce per-episode costs spurred by their participation in the demonstration project. From the case studies, the evaluators concluded that treatment agencies were not planning to change their behavior in ways that threatened access or quality of care.

Subsequent evaluation reports will focus on utilization, cost, and quality effects beyond the 120-day episode

period. There will be further case-study results on agency response to the demonstration and an extension of previous work on cost impacts to include an analysis of agencies' financial performance. Finally, supplementary analyses will consider the representativeness of the demonstration sample and the patient selection behavior of agencies.

95-094 **Quality Assurance for Phase II of the Home Health Agency Prospective Payment Demonstration**

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| Project No.: | 500-95-0028 |
| Period: | September 1995-September 2000 |
| Funding: | $2,799,265 |
| Award: | Contract |
| Principal Investigator: | Peter W. Shaughnessy, Ph.D. |
| Awardee: | Center for Health Policy Research<br>1355 S. Colorado Boulevard, Suite 306<br>Denver, CO 80222 |
| HCFA Project Officer: | Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

Description: This project was designed to test the effect of per-episode prospective payment on the quality of care provided to Medicare patients receiving home care. Home health agencies (HHAs) receive an agency-specific episode payment based on 120 days of care and outlier payments, reimbursed at per-visit prospective rates, for episodes that extend beyond 120 days. A new episode of care is identified when there has been a gap in home health services for 45 or more days after the initial 120 days. Agencies receiving per-episode payments are subject to stop-loss and profit-sharing provisions, as well as case-mix adjustments. Ninety volunteer HHAs from five States (California, Florida, Illinois, Massachusetts, and Texas) were randomly assigned to either the control group (cost-based payment) or the treatment group (per-episode payment). All HHAs had entered the demonstration by January 1996. Since there is an incentive to underserve patients with per-episode prospective payment, data collection using a scaled-down version of the outcome-based quality improvement system was initiated about a year into Phase II of the demonstration. The period from May 1996 to July 1997 indicated a small difference in the end-results outcomes between treatment (per-episode payment) and control agencies (cost-based payment), with treatment-agency patients displaying slightly less favorable outcomes than control-agency patients.

Status: As of December 31, 1998, all participating agencies ended participation in the quality assurance component of the prospective payment system demonstration. All data collection was completed in January 1999. A final report is due to HCFA in September 2000.

98-226 **Normative Standards for Medicare Home Health Utilization**

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|---|---|
| Project No.: | 500-96-0004/03 |
| Period: | September 1998-September 2000 |
| Funding: | $543,170 |
| Award: | Task Order |
| Principal Investigator: | Robert Schlenker |
| Awardee: | Center for Health Policy Research<br>1355 S. Colorado Boulevard, Suite 306<br>Denver, CO 80222 |
| HCFA Project Officer: | Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

Description: Section 4614 of the Balanced Budget Act of 1997 requires that the Secretary develop and establish "normative standards" for home health claims denials. This task order will develop a model that HCFA could use to generate normative standards and guide HCFA claims determinations and other oversight activities. The model will identify qualitative normative standards for home health care service delivery, which could be used to both monitor and enhance the quality of care, and ensure clinically appropriate payment and payment denial decisions. Once developed and tested for both validity and reliability, this model could be used by HCFA to establish a system of clinically appropriate standards for home health services based on scientifically determined thresholds for payment authorization within home health service categories.

Status: An interim report, addressing preliminary analytic work toward the development of a normative standards model, was submitted to HCFA. The preliminary work followed the approach outlined in the Final Model Development Plan.

97-215 **Design of an Integrated Post-Acute Care System**

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| Project No.: | 500-96-0008/04 |
| Period: | September 1997-September 1999 |
| Funding: | $829,428 |

Award: Task Order
Principal Investigator: Robert L. Kane, M.D.
Awardee: University of Minnesota
420 Delaware Street, SE.
Minneapolis, MN 55455-0392
HCFA Project Officer: Frederick G. Thomas III, C.P.A., M.S.
Office of Strategic Planning

Description: HCFA intends to create an infrastructure of post-acute and long-term care delivery and payment systems that are better integrated and more flexible in meeting the needs of beneficiaries with chronic illnesses and disabilities. The transition from our current benefit and provider-based system to a beneficiary-centered system requires several elements:

- An assessment tool that can be used and shared across provider types.
- More flexible benefit packages.
- Funding based on beneficiary health and functional needs.
- Case management that involves formal and informal caregivers in care planning and supports and encourages, where appropriate, beneficiaries to direct their own care.

Additional work that incorporates beneficiary preferences into outcome measures, as well as further attempts to differentiate outcomes by post-acute-care modality for different patient conditions, is also needed. The purpose of this project is to design several elements needed in a more integrated system--an assessment tool, potential case management models, appropriate payment systems, and outcome measures that cross settings and incorporate beneficiary preferences, with the ultimate intent of pilot testing and refining these elements in a demonstration. A second purpose of this project is to design an optional demonstration that tests the feasibility and effectiveness of creating a more integrated post-acute-care system.

Status: Work has begun on developing potential case-management models, as well as an assessment instrument.

99-038 **Design, Development, Implementation, Monitoring and Refinement of a Prospective Payment System for Inpatient Rehabilitation**

Project No.: 500-95-0056/08
Period: July 1999-January 2001
Funding: $1,912,594

Award Task Order
Principal Investigator: Grace Carter
Awardee The RAND Corporation
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138
HCFA Project Officers: Carolyn Rimes
Center for Health Plans and Providers
J. Donald Sherwood
Center for Health Plans and Providers

Description: The purpose of this task is to support HCFA to design, develop, implement, monitor, and refine a case-based prospective payment system for rehabilitation facilities providing services to Medicare beneficiaries. Based upon previous research completed by researchers at RAND, HCFA will be implementing a case-based classification-based rehabilitation prospective payment system. However, previous research has included the non-Medicare population, as well as assessed the classification system primarily on data and information collected by UDSmr, a Division of UB Foundation Activities, Inc., and MEDIRISK, Inc. This research will assess and develop a classification system based upon both UDSmr and MEDIRISKdata and focused on the Medicare population. Under this task order HCFA envisions the following major tasks:

- Develop a Classification System and a Prospective Payment Model for Inpatient Rehabilitation. This project will be merging most recent (1996 and 1997) Medicare Provider Analysis and Review, UDSmr, and MEDIRISK information to replicate previous RAND studies.
- Using the data base created in the previous task, address effects of teaching hospitals and relationships that Medicaid patients may have on the classification and payment system. Identify what, if any, adjustments are needed to take into account patients and providers for whom functional data may be lacking.
- Explore, assess and analyze using qualitative and quantitative techniques information (if accessible) available from the minimum data set for post-acute care (MDS-PAC) preliminary studies. Determine the potential feasibility of including or considering during the refinement phase additional MDS-PAC variables.
- Explore and consider the implications of any potential inclusion of MDS-PAC variables as a part of or refinement possibilities of the MDS-PAC data. Using the products developed in the previous tasks,

create a classification system for Medicare beneficiaries restricted to freestanding inpatient rehabilitation hospitals and exempt units (i.e., not including long-term care hospitals), and assess the impact of this classification system.

- C Develop a prospective payment system based upon the replicated and possibly expanded FIM-FRG Medicare rehabilitation classification system.
- C Simulate the potential impact of the FIM-FRG classification system and subsequent payment system. Included in this simulation should be at a minimum: teaching and nonteaching facilities; urban and rural providers; for-profit and not-for-profit facilities, units and hospitals; and regional distinctions.
- C Design and make recommendations regarding a monitoring system to be used by HCFA following the implementation of this classification and prospective payment system for Medicare rehabilitation patients. Use of the MDS-PAC to collect case-based data assumes that information will be collected at admission and discharge. Integrate the information available or potentially available from the MDS-PAC to process a monitoring system.
- C Develop a timeframe for consideration of refinements to the developed Medicare rehabilitation prospective payment system, including recommendations for potential areas for refinement, additional study or expansion.

Status: The contractor is preparing preliminary analyses.

99-034 **Describing and Assessing the Implication of Developing and Implementing a Prospective Payment System for Long-Term Care Hospitals**

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|---|---|
| Project No.: | 500-95-0055/04 |
| Period: | June 1999-April 2000 |
| Funding: | $599,831 |
| Award: | Task Order |
| Principal Investigator: | Korbin Liu |
| Awardee: | The Urban Institute<br>2100 M Street, NW.<br>Washington, DC 20037 |
| HCFA Project Officers: | Carolyn Rimes<br>Center for Health Plans and Providers<br>J. Donald Sherwood<br>Center for Health Plans and Providers |

Description: This project will assess the implications for developing a prospective payment system (PPS) for long-term care hospitals. The Balanced Budget Act of 1997 requires the development of a PPS for long-term care hospitals. These specialty hospitals were part of the exemptions from PPS. Because this system was developed for acute care hospitals with short-term stays, exclusions were granted for hospitals whose service patterns were not reflected in the diagnostic groups used in PPS. These legislative exemptions generally refer to services provided in four sites: skilled nursing facilities (SNF,) home health agencies (HHA), rehabilitation hospitals, and long-term care hospitals. However, the legislation also mandated that the new payment systems be developed and implemented for these sites on a dictated schedule.

The PPS for skilled nursing homes was effective July 1998, and development and implementation of payment systems for other post-acute care components (home health and rehabilitation facilities) are in progress. Long-term care hospitals are hospitals with average lengths of stay of 25 days or longer, and they are not otherwise classified as rehabilitation or psychiatric hospitals. These hospitals are diverse and provide a range of services including; comprehensive rehabilitation, respiratory therapy, cancer and trauma treatment, as well as pain and wound management. Under their exempted status, since 1986 Medicare payments on average have increased 35 percent annually.

Until 1986, payments for SNF, home health, long-term care, and inpatient rehabilitation facilities accounted for a small percentage of the total Medicare expenses. However, after the implementation of Medicare's hospital PPS in 1984, Medicare spending for these services began to escalate. As an example, Medicare payments grew from $2.5 billion in 1986 to $30 billion in 1996 for SNF and home health care. Payments for the other components also increased. For long-term care hospitals payments increased 28 percent between 1985 and 1995, from $10 million to $120 million. Medicare has reimbursed PPS-exempt facilities, such as long-term care hospitals, on a cost basis. This increase in Medicare payments, which can be viewed as a shift in resources from the acute care sector, also reflects an increase in the number and type of providers. Although SNF and home health have had the most rapid increases, long-term care hospitals have exhibited a similar pattern, i.e., they have had annual increases of approximately 12 percent, increasing from 90 facilities in 1990 to 200 in 1997. Long-term care facilities are generally concentrated geographically, with the majority located in the east. While limited information is available on the number and utilization of long-term care hospitals, there is also little

information available on the characteristics of their patients. Long-term care hospitals may represent the most heterogeneous and least studied components of the PPS-exempt providers. This project involves four major tasks:

- C Construction of a data base describing and analyzing the universe of long-term care hospitals (including any units subsequently defined/certified or licensed as long-term care hospitals) in terms of: facility characteristics, beneficiary use, beneficiary characteristics including diagnoses, referral, transfer and discharge patterns and relationship of these facilities with acute care and other care providers, including SNFs, HHAs and rehabilitation hospitals. This data base will include variables that will facilitate comparing and contrasting regional/geographic variation for those areas with and without long-term care facilities, contrasting patient characteristics and patterns of utilization for long-term care and rehabilitation hospitals, as well as SNFs and HHAs.
- C Use of this information and other related information to describe and analyze the long-term care hospitals and their interrelationship with other components of the health care system.
- C Analysis and assessment of discharge diagnoses from long-term care and acute-care hospitals. This will include a detailed analysis of the treatment patterns for patients; International Classification of Diseases, 9th Revision, Clinical Modification codes; and age, gender, and disposition codes, including principal and additional diagnoses and procedural codes, as available.
- C Preparation of a report that describes long-term care hospitals and makes recommendations regarding the impact of developing and implementing a PPS for long-term care hospitals, including augmenting or modifying the diagnosis-related group system.

Status: The contractor is in the process of developing the data base for this project.

**TELEMEDICINE DEMONSTRATION PROGRAM**

Description: In October 1996, HCFA began a demonstration of Medicare payment for telemedicine services. The demonstration focuses on medical consultations involving a primary care physician and a patient located at a remote, rural (spoke) site and a medical specialist (consultant) located at a medical center (hub) facility, with the primary care physician seeking advice from the consultant concerning the patient's condition or course of treatment. It focuses primarily on teleconsultation as contrasted with other telemedicine applications such as teleradiology and telepathology, for which Medicare payment is already generally available. Using its demonstration authority, HCFA is allowing provider reimbursement for teleconsulting services delivered to Medicare beneficiaries. Originally, the demonstration involved 57 Medicare-certified facilities associated with five telemedicine projects. In June 1998 the demonstration was expanded to include 105 facilities within these projects and extended for 2 years beyond its original 3-year time frame. The demonstration is now scheduled to be completed on September 30, 2001. Through this demonstration, HCFA is addressing concerns that certain populations, primarily persons in rural areas, have limited access to health care specialists and that recent advances in telecommunications technology can provide low-cost access to medical specialists. Medical services, especially clinical consultations rendered through the use of telecommunications technology, generally are not covered by private third-party payers or by Medicare. In the case of Medicare, existing coverage rules specify that services be provided in accordance with accepted professional standards, which for clinical consultation means a face-to-face encounter between patient and physician. The objectives of this demonstration are to assess the feasibility, acceptability, cost, and quality of services available through the use of teleconsultation. HCFA is evaluating the effects of such payment on access to service and quality of care. The evaluation is being accomplished through a coordinated effort involving current evaluation activities at the demonstration sites and a global evaluation cooperative agreement award.

94-214 **Evaluation of Clinical and Educational Services to Rural Hospitals via Fiber Optic Cable**

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|---|---|
| Project No.: | 18-P-90254/7-01 |
| Period: | September 1993-September 2001 |
| Funding: | $698,322 |
| Award: | Grant |
| Principal Investigator: | Jay Freisen, M.D. |
| Awardee: | Iowa Methodist Health System<br>1200 Pleasant Street<br>Des Moines, IA 50309 |
| HCFA Project Officer: | Lawrence E. Kucken<br>Office of Clinical Standards and Quality |

94-211 **Rural Telemedicine Demonstration**

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|---|---|
| Project No.: | 95-P-90367 |
| Period: | September 1994-September 2001 |
| Funding: | $635,366 |
| Award: | Grant |
| Principal Investigator: | Susan Gustke |
| Awardee: | East Carolina University<br>School of Medicine<br>Greenville, NC 27858 |
| HCFA Project Officer: | Lawrence E. Kucken<br>Office of Clinical Standards and Quality |

94-065 **Bundled Payment for Physician and Hospital Services Using Telemedicine Services**

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|---|---|
| Project No.: | 95-C-90384/3 |
| Period: | July 1994-September 2001 |
| Funding: | $1,897,168 |
| Award: | Grant |
| Principal Investigator: | Kevin Halbritter, M.D. |
| Awardee: | West Virginia University Research Corporation<br>P.O. Box 6845<br>Morgantown, WV 26506-6845 |
| HCFA Project Officer: | Lawrence E. Kucken<br>Office of Clinical Standards and Quality |

94-066 **Midwest Rural Telemedicine Consortium: A Pilot Demonstration Project**

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|---|---|
| Project No.: | 95-P-90425/7 |
| Period: | July 1994-September 2001 |
| Funding: | $3,329,236 |
| Award: | Grant |
| Principal Investigator: | Jim Reid |
| Awardee: | Mercy Foundation<br>Sixth and University<br>Des Moines, IA 50314 |
| HCFA Project Officer: | Lawrence E. Kucken<br>Office of Clinical Standards and Quality |

94-063 **Effects of Telemedicine on Accessibility, Quality, and Cost of Health Care**

| | |
|---|---|
| Project No.: | 18-P-90332/5 |
| Period: | July 1994-September 2001 |
| Funding: | $644,086 |
| Award: | Grant |
| Principal Investigator: | F. W. Womack |
| Awardee: | University of Michigan<br>3003 South State Street<br>Ann Arbor, MI 48109-1274 |
| HCFA Project Officer: | Joel W. Greer, Ph.D.<br>Office of Strategic Planning |

Description: This project evaluated the effect of telemedicine systems on accessibility, quality, and cost of health care. A detailed methodology for evaluating telemedicine was developed by a panel of experts and implemented in existing telemedicine programs at the Medical College of Georgia (MCG) Telemedicine Center and Mountaineer Doctor Television (MDTV) at the Health Sciences Center, West Virginia University (WVU). Included in the evaluation design was a quasi-experimental survey study of clients and providers in selected experimental and control communities and a case-control study to compare the content, process, and outcomes of episodes of care with and without telemedicine. The project plan had three goals:

- Development of a detailed methodology for a comprehensive evaluation of the effects of telemedicine on accessibility, utilization, quality, and cost of health care, using a panel of experts on quality, economics, clinical medicine, and technology.
- Implementation and testing of the evaluation design at the MCG Telemedicine Center.
- Extending the evaluation design to MDTV at WVU.

The general hypothesis guiding this research was that telemedicine will improve accessibility to health care, enhance the quality of care delivered, and contain costs.

Status: The final report is being prepared.

95-023 **Maximizing the Effective Use of Telemedicine: A Study of the Effects, Cost Effectiveness, and Utilization Patterns of Consultation via Telemedicine**

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|---|---|
| Project No.: | 18-C-90617/8-03 |
| Period: | September 1995-September 2001 |
| Funding: | $1,514,460 |
| Award: | Cooperative Agreement |
| Principal Investigators: | Jim Grigsby, Ph.D. and<br>Robert E. Schlenker, Ph.D. |

Awardee: Center for Health Policy Research
1355 S. Colorado Boulevard, Suite 306
Denver, CO 80202
HCFA Project Officer: Joel W. Greer, Ph.D.
Office of Strategic Planning

Description: This project is evaluating the medical effectiveness, patient and provider acceptance, and costs associated with telemedicine services, as well as their impact on access to care in rural areas. The demonstration involves ten rural hospitals, one rural referral hospital, and one urban hospital. Planned services for the demonstration include interactive video consults for teleradiology, telepathology, and, where available, telesonography, electrocardiography, and fetal monitoring strips. Payment for related physician services is expected to be made under a waiver of Medicare payment regulations. The goal of he project is to evaluate whether specialty telemedicine services provided by hospital networks produce change with respect to medical effectiveness, patient and provider satisfaction, cost, and access. Hypotheses include telemedicine improving differential diagnoses and treatment, patients and providers being as satisfied with telemedicine as with on-site services, telemedicine services being less costly than on-site services, and telemedicine improving access to a wider range of health care services.

Status: The evaluation design has been completed and the instrument approved by the Office of Management and Budget. Data collection began in September 1997.

98-270 **Medicare Telemedicine Payment Demonstration: Georgia**

Project Period: 95-W-00009/4-01
June 1998-September 2001
Award: Waiver-only Project
Principal Investigator: Max Stachura, M.D.
Awardee: School of Medicine
Medical College of Georgia
Augusta, GA 30912
HCFA Project Officer: Lawrence E. Kucken
Office of Clinical Standards and Quality

99-049 **Expansion of Telehealth Services for Homebound Medicare Beneficiaries**

Project No.: 500-95-0062/05
Period: September 1999-June 2000
Funding: $111,448
Award: Task Order
Principal Investigator: Andrea Hassol
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: Craig Dobyski
Center for Health Plans and Providers

Description: This project is preparing a report that examines the possibility of making payments for medical services provided to Medicare beneficiaries who are "homebound or nursing homebound and for whom being transferred for health care services imposes a serious hardship." The report will examine several possible payment models and include detailed cost and savings estimates of providing home telecare to eligible Medicare beneficiaries using various payment models. The Balanced Budget Act of 1997 requires HCFA to report on the possibility of making payments for a professional consultation that is delivered via telecommunications systems with a physician or practitioner (who is thus furnishing a service for which payment may currently be made). Eligible beneficiaries include Medicare beneficiaries who do not reside in a rural health provider scarcity area. HCFA already has acquired a report (*Home Telecare in the US*) which focuses primarily on how telemedicine is being used in the home care setting. This earlier study found no indication that professional consultations, via telecommunications systems, are being provided in the home where there is a practitioner on each end of an interactive audio video telecommunications system. The research indicates that three existing services models are in use:

- Digital monitoring of patient.
- Nurse cognitive televisit.
- Primary care or specialist cognitive televisit.

Further analysis reveals that home telecare may be better suited for certain diagnoses. For instance, most programs that were contacted targeted congestive heart failure, chronic obstructive pulmonary disease and asthma. Diabetes, wound care, and mild dementia were also included in several programs. Many programs provided home telecare in addition to regular home care so the volume of encounters with homebound patients appears to rise for programs using telemedicine in the home. Additionally, this earlier report indicates that most home telecare is provided to patients who are homebound,

while very little home telecare is being provided to patients who reside in nursing homes.

In addressing payment models, HCFA is seeking recommendations regarding the construction of model visit(s), diagnoses most suitable for home telecare, and appropriate time frames defining episodes of care. Additionally, the feasibility of each payment model would be assessed as it relates to the cost/savings analysis section of the report. To that end, HCFA is seeking recommendations regarding the preceding payment models, as well as other possible options that may or may not be suitable for the cost/savings analysis of the report.

Status: A pro/con analysis has been conducted for various payment models with recommendations on which models to include within the cost/savings analysis.

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## Theme 3: Research on the Future of Medicare

Discussions about the financial viability of the Medicare Trust Funds often focus on the impact of the changing demographic profile which is principally attributable to the aging of the baby boom generation, comprised of individuals born between 1946 and 1964. In addition to the demographic shift, Medicare faces the additional problem that health care inflation consistently exceeds overall inflation. Policy analysts have suggested a broad range of changes to the Medicare program designed to decrease expenditures and raise revenues. HCFA's research provides information to help assess the impact of longer term structural reforms of the Medicare Program necessary to deal with the dramatic increase in the number of beneficiaries.

99-030 **Programming and Data Base Support for Examining Physician Opt-Out Access Issues**

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|---|---|
| Project No.: | 500-96-0516/08 |
| Period: | May 1999-June 2000 |
| Funding: | $33,320 |
| Award: | Task Order |
| Principal Investigator: | Celia H. Dahlman |
| Awardee: | CHD Research Associates, Inc.<br>5515 Twin Knolls Road #322<br>Columbia, MD 21045 |
| HCFA Project Officer: | William J. Buczko, Ph.D.<br>Office of Strategic Planning |

Description: The Balanced Budget Act of 1997 permitted physicians and some nonphysician providers to opt out of the Medicare program. Under the legislative provisions for opting out, physicians providing their carriers with affidavits stating their desire to opt out of Medicare could withdraw from the program for a 2-year period. During this period, these physicians could not bill Medicare for any patient services except those provided during an emergency. These physicians could only treat Medicare beneficiaries under private contracts specifying that the beneficiary bore all financial responsibility for payment and no billing could be sent to Medicare. Under these conditions beneficiaries would face strong incentives to find a physician who would accept Medicare payment. While it is not possible to determine which beneficiaries have signed private contracts and which are not receiving treatment, claims data can be used to determine the extent to which beneficiaries previously treated by opt-out physicians were able to retain access to care under Medicare. This project involves the creation of data files and production of descriptive statistics for Part B claims for calendar years 1997 and 1998 for Medicare beneficiaries who had been treated in 1997 by physicians who chose to opt out of Medicare in 1998. The analysis of these data will assist HCFA in evaluating whether beneficiaries who had been patients of opt-out physicians were able to find other physicians to continue their care.

Status: The 1997 claims for opt-out physicians have been extracted and put into files. Extracts of all Medicare Part B records for patients of opt-out physicians are being extracted. Utilization files for these beneficiaries will be constructed during February 2000.

IM-106 **Macroeconomic Effects of Prescription Drug Proposals for Medicare**

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|---|---|
| Funding: | Intramural |
| HCFA Project Directors: | Edgar A. Peden, Ph.D.<br>Office of Strategic Planning<br>Jean Stiller, M.A.<br>Office of the Actuary |

Description: The purpose of this project is to examine the economic and budgetary effects of several proposals to provide prescription drugs under the Medicare program. It will use the University of Maryland's Inforum macroeconomic model to look at the effects on overall Federal spending and Federal spending for prescription drugs, as well as the effects on economic growth, interest rates, and the price and output effects in the drug industry. As such, the study will look at alternative economic assumptions regarding possible reactions to the program on the part of beneficiaries and the drug industry.

Status: The study is only now getting underway. We now have a contract with the University of Maryland to run its model.

99-082 **Designing Alternative Medicare Fee-for-Service Products**

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|---|---|
| Project No.: | 500-95-0056/10 |
| Period: | September 1999-July 2001 |
| Funding: | $211,609 |
| Award: | Task Order |
| Principal Investigators: | Jose Escarce and Bill Wrightson |
| Awardee: | The RAND Corporation<br>1700 Main Street, P.O. Box 2138<br>Santa Monica, CA 90407-2138 |
| HCFA Project Officer: | Michael Kendix, Ph.D.<br>Office of Strategic Planning |

Description: This project is designing Medicare fee-for-service (FFS) products that might offer alternatives to current Medicare+Choice offerings and commercial Medigap plans. Current FFS Medicare carries significant out-of-pocket expenditures, leading many beneficiaries to purchase Medigap policies. Depending on the Medigap policy type, beneficiaries often receive first dollar coverage for services, which creates incentives for over-utilizing services. If beneficiaries cannot afford or obtain a Medigap policy, they may be able to enroll in a Medicare+Choice plan. Unfortunately, the availability of such plans is limited in some areas and managed care plans are leaving some markets, with the result that some beneficiaries are searching for alternative coverage.

The research results produced from this project will be used with a view to designing a Medicare demonstration along these lines. The Medicare FFS program remains the most popular among the array of alternatives offered to Medicare beneficiaries. The number of plan types that are available to Medicare beneficiaries has increased in recent years, in part due to the Balanced Budget Act of 1997 and the introduction of the Medicare+Choice program. Despite this, inroads into the share of the Medicare population choosing traditional FFS have been modest. One possible alternative is to provide Medicare beneficiaries with a combination of FFS coverage and limited out-of-pocket expenditure.

HCFA is interested in examining alternative models from the viewpoint of both Medicare beneficiaries and the financial impact on the Medicare program. The proposed study design offers the specifics of such an alternative configuration of Medicare FFS and would analyze the impact on the above. Under this analysis, different levels of out-of-pocket exposure that could arise from variation in premiums, coinsurance rates, copayments, and deductibles, would be estimated.

Status: In progress.

99-048 **Design and Simulation of Alternative Medigap Structure**

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|---|---|
| Project No.: | 500-95-0059/07 |
| Period: | September 1999-July 2001 |
| Funding: | $579,036 |
| Award: | Task Order |
| Principal Investigator: | Lisa Maria Alecxih |
| Awardee: | Lewin-VHI, Inc.<br>9302 Lee Highway, Suite 500<br>Fairfax, VA 22031-1214 |
| HCFA Project Officer: | Michael Kendix, Ph.D.<br>Office of Strategic Planning |

Description: While Medicare benefits are extensive, like many insurance products, the program has deductible and co-insurance requirements as well as limitations on payments to providers. On average, basic Medicare benefits alone cover about half the personal health care expenditures of aged beneficiaries (Laschober and Olin, 1996). Because of these "gaps" in coverage, many beneficiaries choose to purchase a supplemental policy, often called "Medigap." The project will compile premium data on existing standard Medigap premiums, formulate alternative standard benefit packages, and estimate premium costs of these alternative packages. From this analysis, the current and alternative Medigap options will be compared.

Though Medicare supplemental coverage has been available since nearly the inception of the Medicare program itself, prior to the enactment of the Social Security Disability Amendments of 1980, such insurance products were regulated only by States. Increasing concerns regarding the confusing array of different Medigap products, questionable marketing and sales practices, sales of overlapping and duplicative coverage, and low loss ratios prompted Congress in 1980 to establish Federal standards for Medigap plans. Most States adopted the standards, which were developed by the National Association of Insurance Commissioners. Continued concern regarding marketing abuses and confusion among beneficiaries eventually prompted Congress to mandate Medigap policy standards. As a result of the Omnibus Budget Reconciliation Act of 1990, effective in 1992, newly issued Medigap policies

have been required to conform to one of ten standardized benefit packages. The law also mandated other standards, including minimum loss ratios and a guaranteed open enrollment period for new Medicare enrollees. Despite many changes in the Medicare program since the early 1990s, the basic benefit structure of Medicare supplemental insurance has remained unchanged. This project will examine possible updated Medigap benefit structures, and compare these alternatives to the premiums and benefit structures of currently available supplementary coverage, as well as Medicare+Choice options.

Status: In progress.

98-225 **Potential Effects of Medicare Program Changes on Medicaid Expenditures**

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|---|---|
| Project No.: | 500-95-0055/03 |
| Period: | August 1998-January 2000 |
| Funding: | $157,509 |
| Award: | Task Order |
| Principal Investigator: | Marilyn Moon |
| Awardee: | The Urban Institute<br>2100 M Street, NW.<br>Washington, DC 20037 |
| HCFA Project Officer: | Brigid Goody, Sc.D.<br>Office of Strategic Planning |

Description: Among the many proposals designed to ensure the viability of the Medicare trust funds are those that would reduce the number of beneficiaries by raising the age of entitlement to either 67 or 70. Health care costs now paid for by Medicare would be shifted to individuals, their employers and other public programs, including Medicaid. Because of a complex set of eligibility rules and program interactions, there are multiple ways in which raising the Medicare eligibility age may result in changes to Medicaid program expenditures. The purpose of this study is to estimate the changes in Medicaid program expenditures that would result from changes to Medicare's eligibility age and to allocate these expenditures between State and Federal governments and among States. Results of this study will help to determine the extent to which savings in Medicare program expenditures may be offset by increased State and Federal Government expenditures for the Medicaid program.

Status: The draft final report has been reviewed and the authors are making final revisions. Raising the Medicare eligibility to either 67 or 70 years old will have important impacts on the Medicaid program. Of those losing Medicare eligibility, 9.3 percent will be covered by Medicaid if the eligibility were raised to 67. The most important changes for the Medicaid program would involve new medically needy individuals when low-income persons lose both Medicare and Qualified Medicare Beneficiary/Specified Low-Income Medicare Beneficiary protections. Expenses for these individuals vary significantly across States since not all States have such a program and those that do range from very stringent cutoffs to very liberal rules. The largest increases in the Medicaid populations, as well as the largest increases in projected new spending, would occur in California, New York, and Texas. In addition to these impacts on Medicaid, 8.4 percent of those losing Medicare eligibility if the eligibility age were raised to 67 would have no health insurance coverage.

IM-099 **Diffusion of Health Technology: a Case of SSRI**

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| Funding: | Intramural |
| HCFA Project Director: | Jay P. Bae, Ph.D.<br>Office of Strategic Planning |

Description: A class of new drugs, known as selective serotonic reuptake inhibitors (SSRI), represents a breakthrough in treatment of depression. Known by more familiar brand names like Prozac, Zoloft, and Paxil, this class of neurotransmitter drugs proved to be highly effective in treatment of depression since its introduction a decade ago.

This paper considered market penetration of these new and innovative antidepressant drugs as a case of health care technology diffusion and analyzes factors influencing diffusion rates. The study utilized Medicaid State drug use files, which report quarterly numbers of prescriptions and reimbursement amount at the 12-digit National Drug Code level from 1991 to 1997 for each State and Washington, DC. Area health care sector structure and socioeconomic characteristics were controlled. Available variables related to health care workforce compositions included physician supply by specialty, such as primary care and psychiatrists, and supply of nonphysicians, such as clinical psychologists, clinical social workers and nurse practitioners. Socioeconomic variables potentially useful for the study included education, income, employment, degree of urbanization, and various household characteristics.

Status: This research project began in the last quarter of 1998. Analysis will be completed by June of 1999 and the results will be presented at a conference.

99-037 **Health Status and Medical Treatment of the Future Elderly: Implications for Medicare Program Expenditures**

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|---|---|
| Project No.: | 500-95-0056/09 |
| Period: | June 1999-March 2001 |
| Funding: | $1,260,259 |
| Award: | Task Order |
| Principal Investigators: | Dana Goldman, Ph.D., and Michael Hurd, Ph.D. |
| Awardee: | The RAND Corporation<br>1700 Main Street, P.O. Box 2138<br>Santa Monica, CA 90407-2138 |
| HCFA Project Officer: | Linda Greenberg, Ph.D.<br>Office of Strategic Planning |

Description: This project is designed to develop demographic-economic models to project how changes in health status, disease, and disability among the next generation of the elderly will affect future Medicare spending. The goal of this task order is to enable HCFA actuaries and policymakers to simulate the impact of changes in health and functional status, as well as changes in medical technology, on future costs to the Medicare program. The first aim of the model will be to answer the question: "If the current trends in demographics continue, and if the future generation of the elderly face the same health status and health care environment as today's elderly, what will future health care costs be?" The second aim of the model will be to serve as the simulation vehicle for evaluating "what if" scenarios to explore how various assumptions about changes in the health status of the elderly and the health care environment will affect Medicare and non-Medicare costs.

The models will focus on two key determinants of health spending: diseases (and the medical technology to treat them) and health status. RAND will use literature reviews and technical expert panels (TEPs) to guide the model development effort. The literature review effort will focus on five areas:

- Health and disability trends.
- New medical treatments.
- Effects of new technologies on morbidity and mortality.
- Diseases most likely to affect the elderly's future health expenditures.
- Past efforts to model health care expenditures.

The first TEP--consisting primarily of physicians knowledgeable about treatments for the elderly--will identify conditions likely to affect expenditures by the future elderly. For each condition, the TEP will identify the emerging technologies and estimate likely consequences on mortality and morbidity. The second TEP--consisting primarily of social scientists and modelers--will help determine appropriate health status measures, methodologies, and data sets for estimating model parameters, and the best modeling techniques.

RAND will use a microsimulation model to estimate future Medicare expenditures. The modeling efforts will consist of three components: a "basic" model, a "health status" model, and a "what if" model. The "basic" model will categorize the future elderly population by age and sex, then iteratively apply a transition matrix to calculate the status of the population at later time periods. This will serve as a useful benchmark for subsequent modeling efforts. The "health status" model will augment the basic model to explicitly include health status so that RAND can explore the possibility that changes may occur in the health status of the elderly and the treatment of particular health conditions among the elderly. RAND will use longitudinal datasets to estimate the transition rates--the probability that a person (or persons) with certain demographic characteristics and known health status will transition to another category with a different demographic and health status description over some time period. RAND will estimate the direct costs of health expenditures by fitting parametric models of the distribution of expenditures using existing data that link health status to spending. Finally, the "what if" model will explore changing the parameters of the health status model to reflect possible changes to the health care environment, including medical breakthroughs.

Status: As of December 1999, the project was well underway. In September 1999, a final design report was accepted. In the fall of 1999, project staff consulted with nationally-recognized geriatricians to discuss which disease groups and specific medical conditions should be covered by the medical TEPs. Members have been appointed to the medical and social science TEPs. Preliminary reviews of the literature are expected prior to the TEP meetings. Work on devising a micro-simulation model to estimate future Medicare expenditures is

underway. Final project results are expected by December 2001.

IM-104 **Racial Differences in Outcomes after Hip Fracture**

Funding: Intramural
HCFA Project Director: Jean Scott
Office of Strategic Planning

Description: A number of studies have shown the age-specific incidence of hip fracture to be lower in African Americans than in Caucasians. However, few studies have addressed racial differences in outcomes after hip fracture. The smaller number of hip fractures that occur in African Americans have made it difficult to assemble enough fracture cases to adequately address the issue of differential morbidity and mortality after fracture. This study will take advantage of the opportunity presented by the Medicare data to identify a large enough sample of hip fractures in African Americans to address this issue. The project will take into account issues of pathologic fractures, fractures involving a high level of trauma, and co-morbidities pre-dating the fracture that may affect the outcome. The study will examine whether outcomes after hip fracture differ by race. Specifically, the study will address:

- Whether the mortality after hip fracture is higher in African American women than in Caucasian women.
- Whether the mortality after hip fracture is higher in African American men than in Caucasian men.
- Whether mortality patterns differ between African Americans and Caucasians. (Is there greater short-term mortality after fracture (first 30 days) in one group? Is there greater mortality at 6 months in one group? Do "survival after fracture" curves differ by race?)
- Whether morbidity differs between African Americans and Caucasians. Outcomes are: readmission for related cause, readmission for any cause, nursing home admission (at discharge from fracture; short-term; later admission), occurrence of subsequent fracture (at any site or at sites related to low bone density).
- Whether cost of care in the year after fracture differs between the race groups.

Status: In progress.

IM-105 **Injuries in Elderly Medicare Beneficiaries**

Funding: Intramural
HCFA Project Director: Jean Scott
Office of Strategic Planning

Description: Unintentional injuries accounted for more than 90,000 deaths in the U.S. in 1997, making this the fifth leading cause of death overall. The Healthy People 2000 objectives for improving the health of the U.S. population included unintentional injury as a priority. In spite of a focus in this area, the number of fall-related injuries and deaths are increasing in the elderly population. Fall-related deaths in persons 65 to 80 years of age have increased from 18.1 per 100,000 in 1987 to 19.9 per 100,000 in 1996, a 9.9 percent increase. The 20 percent increase in fall-related deaths in those 85 years and older over the same time period (133.0 per 100,000 to 159.6 per 100,000) is even more dramatic. Falls and fall-related injuries are the second leading cause of injury deaths among those 65 to 84 years of age and the leading cause of injury deaths among those 85 and older. Deaths related to motor vehicle crashes in those 70 and older have increased by 2.2 percent over the past decade (22.6 per 100,000 in 1987 to 23.1 per 100,000 in 1996). At least part of the increase in all of these rates can be attributed to the aging of the U.S. population.

As this aging phenomenon continues and the proportion of "elderly elderly" (those 75 and older) increases, prevention efforts will become more challenging. Data on suicide deaths in the elderly indicate that the rate is decreasing, but national data on mortality and morbidity due to other intentional injuries such as injury due to firearms, blunt trauma, or abusive behavior of caregivers or others, are not readily available.

The goals of this project are to describe the pattern of injury resulting in medical intervention in Medicare beneficiaries, to calculate payments for injury-related care, and to look at trends over time in both patterns of injury and costs. Since many injuries are preventable, the data from this study should be useful in designing and targeting prevention strategies. This is an expansion of work accomplished in an earlier intramural project (*Childhood Injuries in the Medicaid Population*). This earlier project developed a taxonomy of injuries by type constructed through a review of the International Classification of Diseases, 9th Revision, Clinical Modification Codes. The classification identified injuries from the 800-900, and E800-E999 series (supplementary

classification of external causes of injuries and poisonings) and selected other codes outside these series. The work was accomplished in consultation with experts in injury coding from the National Center for Health Statistics. The complete list of codes has been collapsed into both a long and a short list of code groups, which represents a taxonomy of injuries by type. This taxonomy formed the basis of the classification of injury for the study in children. We will use, modify, and expand, as needed, this taxonomy for the study in the elderly.

Status: The initial study approach will be to choose the most recent year for which data are available and perform a descriptive analysis. Problems will be identified and methodology will be refined during this initial analysis. We will then proceed with the analysis of trends over time by going back to data from prior years.

98-234 **Decisionmaking in Managed Care Organizations**

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| Project No.: | 500-95-0048/06 |
| Period: | July 1998-April 2000 |
| Funding: | $257,749 |
| Award: | Task Order |
| Principal Investigator: | Susan Haber |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452-8414 |
| HCFA Project Officer: | Brigid Goody, Sc.D.<br>Office of Strategic Planning |

Description: This task order examines a broad range of managed care decisionmaking strategies, their implications for the development and diffusion of new technologies, and their impact on future health care costs, especially Medicare program costs. The project has three phases:

- The first phase will be comprised of case studies of managed care organizations and will focus on three components of plan decisionmaking related to the scope of insurance coverage: benefits offered, premium and coinsurance structure, and coverage of specific technologies.
- The second phase of the project will extend the case study approach to examine how the research and development decisions of private firms are affected by increased managed care penetration.
- The third phase of the project will involve the development of a conceptual framework for simulating the long term growth in health care expenditures, especially Medicare program costs, which incorporates the interaction between increased managed care penetration and the research and development process.

Status: The contractor is completing interviews with managed care organizations and contracting hospitals. They are also continuing their site visits to research and development companies. The final report will be prepared in the spring of 2000.

## Theme 4: Outcomes, Quality and Performance

Improving beneficiaries' knowledge and ability to make more informed health care choices, both in the health plans they select and in the services they use, is part of a long-term commitment by HCFA to change and improve communication of information to beneficiaries. HCFA's research activities include the development and testing of improved information resources that will enable consumers to choose among health plans and providers based on their relative value and quality. HCFA seeks to better understand how choices are made so that beneficiaries can use information most effectively, and also to develop better tools for measuring health care outcomes and quality, as well as the performance of health plans and providers.

IM-012 **Patterns and Outcomes of Cancer Care in the Medicare Population**

Funding: Intramural
HCFA Project Directors: Gerald F. Riley, James D. Lubitz and Renee Mentnech
Office of Strategic Planning

Description: More than one-half of all cancer patients have Medicare coverage. A data base that links Medicare data with cancer registry data collected through the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program was been created. The SEER program covered approximately 14 percent of the U.S. population. This data base contained information on the anatomic site of the primary cancer, histology, stage of the disease at diagnosis, and date of diagnosis for each new case of cancer in the program's geographic areas. Linking SEER and Medicare data provided opportunities for research on issues of access to medical care, Medicare costs incurred by cancer patients, and patterns of medical care received by cancer patients diagnosed with various sites, stages, and histologies of cancer. Some specific questions addressed through analysis of these data were the following:

- What are overall Medicare costs, by type and stage of cancer?
- What are the Medicare costs that are specifically related to cancer care?
- What comorbidities are associated with cancer and how do they influence Medicare use and cost?
- What is the mix of care (on a per-person basis) among community hospitals, teaching hospitals, and cancer centers?
- What are the institutional factors that influence the type of inpatient hospital care received by cancer patients?

Status: SEER data have been linked to Medicare administrative records for cancer cases diagnosed through 1993. An update of the linkage is being conducted, which will incorporate SEER cancer cases diagnosed in 1994-1996.

IM-030 **Influenza Immunization Initiative**

Funding: Intramural
HCFA Project Director: David K. Baugh
Office of Strategic Planning

Description: The purpose of this project is to provide data for monitoring of HCFA's initiative to improve influenza immunization rates among Medicare beneficiaries. Influenza immunizations are an important measure to prevent morbidity and mortality in our elderly population. In response to the Government Performance and Results Act of 1993 (GPRA), HCFA established a goal of achieving a 59-percent immunization rate among Medicare beneficiaries age 65 or older in fiscal year 1999. In this project, Medicare claims data were analyzed to produce statistics on influenza immunization rates for Medicare beneficiaries. In 1997, the analysis showed that there were Medicare paid claims for influenza immunizations for 43.7 percent of Medicare beneficiaries age 65 or older. This represented an absolute increase of 4.0 percent from 1994 and of 0.7 percent from 1996. The rates were 46 percent for Caucasians versus 24.3 percent for African Americans. These increases also reflected continued progress toward HCFA's goal of at least 59 percent and the Department of Health and Human Services Year 2000 goal of at least

a 60-percent influenza immunization rate for all persons age 65 years or older.

Data from the 1994 National Health Interview Survey (NHIS) indicated a higher overall influenza immunization rate for persons age 65 or older (55 percent) than the Medicare claims data demonstrate. However, the NHIS data corroborated our finding of a substantially lower influenza immunization rate for African Americans than for Caucasians. The 1994 NHIS estimated the elderly African American immunization rate to be approximately two-thirds the rate of Caucasians. Surveys may over-report utilization if they miss the poorest and sickest individuals who have the lowest rates of use. For example, a telephone survey will not reach persons who do not have telephones, while a household survey like the NHIS will exclude women living in institutional settings. Moreover, surveys may encounter recall problems as respondents tend to forget exactly how long it has been since their last influenza immunization and are likely to over-report healthy behaviors. Most probably, the true rate of influenza immunizations lies somewhere between the Medicare claims rate and survey numbers.

Status: For 1996 and 1997, Medicare influenza immunization rates for the nation, each State and each county have been prepared for all persons age 65 or older and for Caucasians and African Americans. Further detail is available by age and gender within these racial groups. The data for 1995 and 1996 can be accessed on HCFA's Internet home page via the address: www.hcfa.gov/quality/docs/flu-6b.htm.

IM-032 **Mammography Utilization Initiative**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director: | David K. Baugh<br>Office of Strategic Planning |

Description: Mammography is particularly valuable in reducing breast cancer deaths among older women, who experience the highest incidence and mortality from breast cancer. In response to the Government Performance and Results Act of 1993, HCFA established a goal of increasing by 5 percent, between 1997 and 1999, the proportion of female Medicare beneficiaries age 65 or older in the United States who receive a screening or diagnostic mammogram within a 2-year period. In this project, Medicare claims data are analyzed to produce statistics on mammography service use rates for Medicare beneficiaries.

Status: Biennial 1996-1997 and annual 1997 mammography service use rate data have been prepared for use by professional review organizations and other groups at the local level in the campaign to increase mammography screening levels.

IM-056 **Nonresponse Bias in the Medicare Beneficiary Health Status Registry**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director: | Marsha G. Davenport, M.D., M.P.H.<br>Office of Strategic Planning |

Description: In 1994, HCFA completed the Medicare Beneficiary Health Status Registry (MBHSR) Pilot Study that was conducted under a contract awarded to Research Triangle Institute. The purpose of the pilot study was to determine the feasibility of using a mail survey with telephone follow-up to collect information on health and health status from Medicare beneficiaries. The intramural studies were designed to describe and evaluate the impact of nonresponse and the potential for nonresponse bias in the MBHSR Pilot Study. Using data from both the pilot study and the Medicare administrative files, respondents and nonrespondents were compared on variables such as age group, gender, race/ethnicity, and patterns of utilization for selected health care services.

Status: The analyses have been completed and manuscripts are in preparation form.

IM-068 **Persons With Acquired Immune Deficiency Syndrome in the Medicare Program**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director: | Michael Kendix, Ph.D.<br>Office of Strategic Planning |

Description: Medicare claims data have been used to determine those Medicare beneficiaries with acquired immunodeficiency syndrome (AIDS). The data contain information on the use of services and program reimbursements for those services. This project evaluated the use of Medicare program services for persons with AIDS. The study identified health services utilization, access to care, and reimbursement patterns of persons with AIDS in the Medicare program.

Status: The project is completed.

IM-072 **Longitudinal Study of Use of Early Preventive Services and Health Outcomes of a Nationally Representative Cohort of Children Born in 1988 and Followed up at Age Three**

Funding: Intramural
HCFA Project Directors: Donna Ronsaville and Rosemarie Hakim, Ph.D. Office of Strategic Planning

Description: The project will use the National Maternal and Infant Health Survey and the 1991 Longitudinal Follow Up Survey to examine the effects of use of early preventive health care on health outcomes to test the hypothesis that adequate use of services improves the health and well-being of children. The survey contains extensive provider information, as well as interview-based information on each child's health and use of services. Children covered under private insurance, Medicaid, and uninsured are in the sample. Health outcomes will include growth and cognitive development as well as common child health indicators such as immunizations and respiratory infections. Factors such as barriers to care, income, race, and continuity of care can be used to predict health outcomes.

Status: Analysis is completed and publications are under review.

IM-076 **Costs of Extra-Renal Transplantation among Medicare Beneficiaries**

Funding: Intramural
HCFA Project Director: Donna Ronsaville, Ph.D. Office of Strategic Planning

Description: Medicare has covered kidney transplants since 1973 and a great deal of literature has been published concerning the outcomes and costs of this procedure. In more recent years, Medicare coverage has been expanded to extra-renal transplantation (heart - 1988, liver - 1991, bone marrow - 1991, and lung - 1995). In 1996, the number of procedures and Medicare expenditures for these procedures was as follows:

| Type | Number | Expenditures |
|---|---|---|
| Heart | 538 | $116 million |
| Liver | 552 | $111 million |
| Bone Marrow | 194 | $ 29 million |
| Lung | 140 | $ 18 million |

However, these are only expenditures for the inpatient stay itself (the diagnosis-related group payment). Physician expenditures and immunosuppressive expenditures have not been documented. In addition, follow-up expenditures as well as pre-transplant expenditures are unknown.

This study identified transplant recipients in the Medicare population and calculated the long term costs to the program for their care. In addition, the study explored the possibility of using the United Network for Organ Sharing wait list to identify Medicare beneficiaries who do not get transplanted but are waiting for a transplant. This enabled estimates to be made of the costs of care and outcomes of persons eligible for transplantation who do not get transplanted due to inadequate supplies of cadaver organs.

Status: The project is completed.

IM-086 **Renal Failure among Medicare Diabetic Population**

Funding: Intramural
HCFA Project Director: Paul W. Eggers, Ph.D. Office of Strategic Planning

Description: The University of Minnesota, under a contract with the Centers for Disease Control and Prevention, created a 100 percent research data base of 3.3 million aged Medicare beneficiaries with diabetes (alive as of 12/31/93). This data base was used to calculate the prevalence of diabetes in the Medicare population, as well as morbidity rates among diabetic persons (hospitalizations for diabetic complications, cardiovascular disease, amputation, and all cause), and access to needed services such as eye care.

This study linked this data base with the end stage renal disease (ESRD) Program Management and Medical Information System (PMMIS) to calculate rates of renal failure among persons with diabetes. Although it has been well demonstrated that diabetes is the most common cause of renal failure, the lack of a reliable population at risk has prevented such estimates from being made. In

addition, this study served as a partial check on the specificity of the University of Minnesota methodology. That is, to the extent that incident cases of renal failure due to diabetes occur in Medicare that are not in the diabetes cohort, the cohort has underestimated actual prevalence.

Status: Initial data processing has begun. Preliminary rates of ESRD have been calculated. Matching with the PMMIS has not begun.

IM-091 **Measuring Functional Status among Medicare Managed Care Enrollees**

Funding: Intramural
HCFA Project Director: Gerald F. Riley
Office of Strategic Planning

Description: This study will use health outcome survey data to examine levels and patterns of functional status among managed care enrollees. Functioning will be measured along several dimensions. Longitudinal patterns (i.e., changes in functional status for individuals over time) will also be examined. Patterns of functional status will be compared by several plan characteristics, such as size and maturity of plan, model type, location, and other factors.

Status: The first round of data will be available in 1999, at which time analyses will begin.

IM-078 **Analysis and Comparison of State and Private Sector Risk-Adjusted Payment Systems**

Funding: Intramural
HCFA Project Director: Frederick G. Thomas III, C.P.A., M.S.
Office of Strategic Planning

Description: This project described in detail the risk-adjusted capitation payment systems being implemented in States and by private payers.

Status: The project is completed and the results were included in the report to Congress.

IM-092 **Utilization among Medicare HMO and Fee-for-Service Enrollees**

Funding: Intramural
HCFA Project Directors: James Lubitz, Ph.D.
Office of Strategic Planning

Description: Utilization data are available for Medicare Current Beneficiary Survey (MCBS) respondents through 1995. The study compared respondents in health maintenance organizations (HMO) and fee-for-service (FFS) on several measures of utilization of Medicare-covered services. Such comparisons had not been possible before because of a lack of encounter data for Medicare HMO enrollees.

The study was descriptive and focused on developing utilization rates for inpatient hospital and prescription drug services. Physician and outpatient services were not included in the analysis because there was differential underreporting between MCBS respondents in HMOs and FFS due to the fact that HMO enrollees do not receive Explanation of Benefits (EOB) forms following use of a covered service. EOBs were thought to help respondents in FFS give a complete accounting of their utilization. An analysis of MCBS and other survey data by Westat suggested that there is a greater degree of underreporting of physician and outpatient services by HMO enrollees in MCBS.

Utilization rates were adjusted for age and sex differences between the HMO and FFS populations, as well as for various health status measures.

Status: Analyses continue.

IM-095 **Changes in the Behavior of Hospital-Based Skilled Nursing Facilities as a Result of the Prospective Payment System**

Funding: Intramural
HCFA Project Director: Frederick G. Thomas III, C.P.A., M.S.
Office of Strategic Planning

Description: As a result of the Balanced Budget Act of 1997, cost-based payments in skilled nursing facilities (SNF) are being replaced with a prospective payment system using resource utilization groups, version III categories. Over the last decade, the fastest growing class of SNF providers are hospital-based units. With changed financial incentives, what economic behavior can be expected from hospitals that own SNFs as a reaction to the new payment system? Two policy questions are relevant:

- Do hospital-based SNFs provide more efficient post-acute care (PAC) than freestanding SNFs?
- Do hospitals skim less intense cases for their own PAC units, and transfer more severely ill cases to freestanding SNFs?

These questions will be analyzed using data from the Multistate Nursing Home Case-Mix and Quality Demonstration and interpreted with relevant economic theories. The empirical results will be assessed for Medicare payment policy significance.

Status: Completion is expected in January 2001.

IM-100 **The Medicare Beneficiary Health Status Registry Pilot Study Analyses**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director: | Marsha G. Davenport, M.D., M.P.H.<br>Office of Strategic Planning |

Description: The Medicare Beneficiary Health Status Registry Pilot Study was conducted under HCFA contract number 500-90-0053 by the Research Triangle Institute. The project was completed in 1994. The pilot study was designed to determine the feasibility of obtaining information on health, health status, functional status, and risk factors from the Medicare beneficiaries. The pilot study methodology used a mail survey with telephone follow-up of nonrespondents. The data from this pilot are the basis for the current ongoing intramural analyses.

Status: Data from the pilot study are presently being analyzed as intramural research projects. These projects include analyses on:

- Nonresponse bias
- Health status characteristics of self-respondents and proxy respondents
- Women's health
- Heart disease
- Asthma
- Mental health

IM-101 **Heart Disease Procedures, Health Status, and Risk Factors from the Medicare Beneficiary Health Status Registry Pilot Study: 1993-1994**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director | Eleanor Janice Collins<br>Office of Strategic Planning |

Description: Research findings suggest differences in the use of cardiac procedures among Medicare beneficiaries. The utilization of these procedures for the elderly may be attributed to differences in overall health, co-morbid conditions, and risk factors such as smoking. It is suggested that further research delineating the relationships and impact among these variables needs to be conducted. This descriptive study evaluated the role of health status, selected diseases, medication use, and risk factors for Medicare beneficiaries who were reported to have had at least one of these cardiac procedures: angioplasty, coronary artery bypass graft, and/or pacemaker implants. The current analyses used data obtained from the Medicare Beneficiary Health Status Registry Pilot Study completed in 1994. Mailed surveys of the Pilot Study were sent to beneficiaries, of which 1,435 were returned completed. Beneficiaries not responding after three waves of mailings were contacted to conduct the survey by telephone. Stratification variables were age group (65 years; 76-80 years), race/ethnicity, history of previous hospitalizations determined from the Medicare administrative files, and gender. Present analyses are based on a subsample of respondents who reported having one or more of the cardiac procedures.

Status: Analyses are ongoing.

98-257 **Development and Validation of Measures and Indicators of the Quality Appropriateness of Services Rendered in Post-Acute and Long-Term Settings Settings**

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|---|---|
| Project No.: | 500-95-0062/04 |
| Period: | September 1998-September 2002 |
| Funding: | $4,403,751 |
| Award: | Task Order |
| Principal Investigator: | Terry Moore |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officers: | Sue Nonemaker<br>Office of Clinical Standards and Quality<br>Karen Schoeneman<br>Center for Medicaid and State Operations |

Description: This task order is developing and validating a comprehensive set of performance measures and indicators of quality for institutional post-acute and long-

term care settings. The post-acute settings involved are: skilled nursing facility short-stay units, inpatient rehabilitation facilities (which include hospital-based rehabilitation units), and long-term care hospitals.

The use of quality measures and indicators, such as those to be developed under this project, will allow HCFA to determine objectively the value of the care it purchases by providing a valid measurement of the care furnished by Medicare-participating providers. The use of these indicators will allow HCFA to better manage Federal resources by providing information that can be used to target quality improvement, enforcement, and program safeguard activities. In addition to its emphasis on institutional long-term care (LTC) providers, HCFA's concern about post-acute care and the way in which acute, post-acute, and LTC interact has been growing. In order to address concerns about cost, quality, and access for Medicare beneficiaries needing post-acute care, HCFA has been granted the authority under the Balanced Budget Act of 1997 to develop a patient assessment system for institutional post-acute providers. HCFA intends that the system be standardized across provider types, in order to allow necessary comparisons to be made about outcomes of care and to support an equitable and more appropriate payment system for post-acute services.

It is expected that the measures that are developed through this project will be used within HCFA's regulatory quality monitoring programs to inform quality improvement activities, to provide information to consumers, and to provide information to payers of health care for use in evaluating the quality and value of services.

Status: The project is underway.

99-136 **Medicare Lifestyle Modification Program--Quality Monitoring and Medical Review**

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|---|---|
| Project No: | CSQ-99-0002 |
| Period: | July 1999-September 2003 |
| Funding: | $639,215 |
| Award: | PRO Contract Amendment |
| Principal Investigator: | Thomas J. Schaefer, D.D.S., M.S. |
| Awardee: | Delmarva Foundation for Medical Care, Inc.<br>9240 Centreville Road<br>Easton MD 21601 |
| HCFA Project Officer: | Mary Pratt, MSN, RN<br>Office of Clinical Standards and Quality |

Description: This is a 4-year payment demonstration implemented to evaluate the feasibility and cost effectiveness of cardiovascular lifestyle modification. Such programs are designed to reduce or reverse the progression of cardiovascular disease and may reduce the incidence of hospitalizations and invasive procedures among patients with substantial coronary occlusion. The demonstration is being implemented initially at participating sites licensed by the Preventive Medicine Research Institute to offer the Dr. Ornish Program for Reversing Heart Disease. The demonstration will be expanded to include one additional multisite lifestyle modification program model. Sites under each model will be able to enroll up to 1800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The Medicare beneficiaries who meet the clinical criteria for enrollment under the demonstration are expected to include only people with substantial coronary artery disease. The demonstration sites will receive 80 percent of a total negotiated fixed payment amount, for each program model, for a 12-month program. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. The Delmarva Foundation for Medical Care, a Peer Review Organization, will perform quality monitoring activities for the demonstration.

Status: Implementation of the demonstration is in progress.

98-248 **Study on Expansion or Modification of Preventive Benefits Provided to Medicare Beneficiaries**

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|---|---|
| Project No.: | 500-98-0275 |
| Period: | September 1998-February 2000 |
| Funding: | $1,333,656 |
| Award: | Contract |
| Principal Investigators: | Marilyn Field and Janet Corrigan |
| Awardee: | National Academy of Sciences<br>2101 Constitution Ave, NW.<br>Washington, DC 20418 |

HCFA Project Officers: Katharine L. Pirotte
Office of Clinical Standards and Quality
Joseph Chin, M.D.
Office of Clinical Standards and Quality

Description: The Balanced Budget Act of 1997 mandated that the National Academy of Sciences, Institute of Medicine (IOM) analyze the expansion or modification of preventive or other services covered by Medicare. The study will include specific findings with respect to coverage of:

- C Nutrition therapy, including parenteral and enteral nutrition.
- C Skin cancer screening.
- C Medically necessary dental care.
- C Routine patient care costs for beneficiaries enrolled in approved clinical trial programs.
- C Elimination of time limitation for coverage of immunosuppressive drugs for transplant patients.

IOM will consider both short-term and long-term benefits and costs to the Medicare program. Attention will then be turned to producing basic estimates of the net costs to Medicare of selected coverage changes. IOM will not recommend that a specific intervention be covered by Medicare. Rather, they will come to conclusions about the clinical status of the intervention and its effectiveness, and the potential impact on Medicare expenditures. The study will also put its findings about specific services in the context of broader processes for making coverage decisions.

Status: The final report (in prepublication form) was completed November 30, 1999. IOM briefed HCFA on the reports on December 9. IOM held a congressional briefing on December 14 and a public briefing on December 15. Published reports will be available by the end of February 2000.

99-070 **Researching and Identifying the Most Effective Provider Education Efforts for Encouraging the Use of Medicare Preventive Services**

Project No.: 500-95-0062/07
Period: September 1999-May 2000
Funding: $325,812
Award: Task Order

Principal Investigator: Gary Gaumer
Awardee: Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138-1168
HCFA Project Officer: William McQueeney
Center for Health Plans and Providers

Description: This project involves the analysis and evaluation of current methods used by fiscal intermediaries and Medicare carriers to educate their provider communities on preventive services specified in the Balanced Budget Act of 1997:

- C Mammography Screening, Pap Smear and Pelvic Exam Screening.
- C Prostate Cancer Screening Tests.
- C Coverage of Colorectal Screening.
- C Diabetes Self-Management Benefits.
- C Standardization of Medicare Coverage of Bone Mass Measurements.
- C Influenza and Pneumococcal Vaccination Outreach.

The project will use focus groups with cross segments of Medicare providers to explore their information needs, including what information they need from HCFA, how such information is currently conveyed, and how such information can best be supplied in the future. In addition to the provider focus groups, the project will also use sub-focus groups to assess preventive health care needs among specific subpopulations who may be at high risk for illnesses related to the preventive services. Some examples are:

- C African Americans and Alaska Natives for diabetes awareness since prevalence of the disease among these groups has been increasing.
- C Vaccination issues for African Americans and Hispanics since vaccination rates among these groups is well below the national average.
- C Cancer awareness (particularly colorectal screening) for persons aged 67 or older because more cancer deaths are reported for this age group than any other.
- C Disabled Medicare beneficiaries and Asian American and Pacific Islander population (the Department of Health and Human Services announced an Asian American and Pacific Islander Initiative since it is unclear if current health programs are effectively reaching this population).

Status: The project is active.

99-060 **Programming Support for Development of the SEER-Medicare Data Base**

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| Project No.: | 500-96-0516/09 |
| Period: | June 1999-November 2000 |
| Funding: | $117,428 |
| Award: | Task Order |
| Principal Investigator: | Celia H. Dahlman |
| Awardee: | CHD Research Associates, Inc.<br>5515 Twin Knolls Road #322<br>Columbia, MD 21045 |
| HCFA Project Officer: | Gerald F. Riley<br>Office of Strategic Planning |

Description: This project provides programming support for the Surveillance, Epidemiology, and End Results (SEER)-Medicare data base. The SEER-Medicare data base has been in existence since 1991 and is the collaborative effort of the National Cancer Institute (NCI), the SEER registries, and HCFA to create a large population-based source of information for cancer-related epidemiologic and health services research. The creation of the linked files requires matching persons reported to the SEER registries with a master file of Medicare enrollment to determine which persons appearing in the SEER data are entitled to Medicare. For persons found to be Medicare enrollees, their Medicare utilization claims are appended to their SEER record. The instant programming services are for the update and maintenance of the SEER-Medicare data, analyses related to the SEER-Medicare data, and analyses related to other Medicare program studies. HCFA and NCI are both providing funds for this effort. The specific parts of the project are:

- Work with HCFA staff who have been involved with past production of the SEER-Medicare data to develop a complete understanding of the process of linking SEER-Medicare data.
- Participate in the linkage of the SEER-Medicare data in fiscal year (FY) 1998/FY 1999 and FY 2001/FY 2002, if the agreement is continued.

Such participation includes, but is not limited to:

- Assessing the quality of the data provided by the SEER registries.
- Matching finders provided by the SEER registries and/or NCI with Medicare enrollment data maintained by HCFA.
- Producing raw or tabular data, as needed, to assess post-production quality.

Extract Medicare claims data for persons identified from the SEER data as being Medicare eligible. Medicare claims will be extracted for all years of Medicare data available at the time of the linkage and for subsequent calendar years between the time of the linkage, as these become available. The production of Medicare claims files may entail creation of raw or tabular data to assess data quality and may require providing NCI or its programming contractor with interim data files. Extract Medicare enrollment and claims data for persons residing in the SEER areas. This file serves as a control or comparison group for studies. These data will be extracted at the same time that data for the SEER-Medicare cases are extracted. Provide a copy of all files to NCI or its designated programming contractor. Preparation of such files includes the removal of personal identifiers, except for interim files used to assess data quality. Maintain the "crosswalk" file that links the case numbers for persons in the SEER data with their Medicare enrollment number. Upon completion of all data quality checks for the linkage, all other data files with personal identifiers submitted by the registries will be destroyed. Maintain all programs and documentation for the process of linking the SEER-Medicare data in a format that the linkage process can be replicated by a programmer not familiar with the project. Provide programming support for analytic projects. Respond to requests for programming, as described above, or for purposes of resolving questions about data quality. Such requests may be initiated by HCFA or NCI. Comply with all privacy and confidentiality regulations regarding the data, as required by HCFA and NCI.

Status: The work is underway.

99-061 **Programming Support for the Development of the SEER-Medicare Data Base to Examine the Hospice Benefit among Aged Medicare Beneficiaries**

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| Project No.: | 500-96-0516/10 |
| Period: | September 1999-September 2000 |
| Funding: | $49,998 |
| Award: | Task Order |
| Principal Investigator: | Celia H. Dahlman |
| Awardee: | CHD Research Associates, Inc.<br>5515 Twin Knolls Road, No. 322<br>Columbia, MD 21045 |

HCFA Project Officer: Linda Greenberg, Ph.D.
Office of Strategic Planning

Description: This project provides programming services for the development of an analytic file of hospice services using the updated Surveillance, Epidemiology, and End Results (SEER)-Medicare data base. The SEER-Medicare data base has been in existence since 1991 and is the collaborative effort of the National Cancer Institute, the SEER registries, and HCFA to create a large population-based source of information for cancer-related epidemiologic and health services research. The creation of the linked files requires matching persons reported to the SEER registries with a master file of Medicare enrollment to determine which persons appearing in the SEER data are entitled to Medicare.

For persons found to be Medicare enrollees, their Medicare utilization claims are appended to their SEER record. Preliminary analyses of the use of hospice services among elderly beneficiaries diagnosed with cancer suggest some differences by age, race, income, and HMO status. However, because these analyses have been confined to colorectal and lung cancer cases diagnosed in 1992 and 1993, the number of cases is quite small. We are augmenting our previous study with more cases from the updated Medicare-SEER data base to include additional cancer sites and additional years. We will examine the sociodemographic determinants of hospice use among all decedent cancer patients, ages 65 and older, and expenditure patterns of users and nonusers of hospice care. Additionally, analyses will focus on differences among cancer patients enrolled in health maintenance organizations (HMO) and fee for service (FFS). We plan to examine:

- Utilization of hospice services among aged decedent cancer patients (e.g., length of time between diagnosis and electing the hospice benefit, and length of stay in hospice), and possible variations in use of hospice services by geographic location and type of hospice.
- Utilization of Medicare-covered services prior to and during hospice care.
- HMO-FFS survival differences adjusting for age, race, social economic status, and clinical variables such as cancer type, stage, and grade.
- Expenditures for users and nonusers of hospice care by year.

Status: The project is in the start-up phase.

IM-079 **Allocating the Overhead Costs of Physician Practices to Their Services**

Funding: Intramural
HCFA Project Director: Edgar A. Peden, Ph.D.
Office of Strategic Planning

Description: Both insurance companies and governments face an ongoing need to pay physician practice costs on a service-by-service basis. One recommended way of doing this is to reimburse based on resource costs, an approach that economists call average cost pricing. A problem that arises with this approach is that practices' overhead costs are not easily assigned to specific services. Based on the activity-based-costing method of accountants, this study uses practice survey data to estimate economic cost functions to assign overhead costs to multiple activities, effectively assigning a unit overhead cost to each. The latter can then be ascribed to specific services based on the activities they require.

Status: Much of the empirical work has been done and a rough draft of the paper describing the analysis has been completed.

98-232 **Survey of Colorectal Cancer Screening Practices in Health Care Organization**

Project No.: HCFA-IA-98-075
Period: September 1998-July 2001
Funding: $816,642
Award: Interagency Agreement
Principal Investigator: Carrie Klabunde, Ph.D.
Awardee: National Cancer Institute
9000 Rockville Pike
Bethesda, MD 20892
HCFA Project Officer: Ann Meadow, Sc.D.
Office of Strategic Planning

Description: Colorectal cancer is the second leading cause of cancer death in the U.S. Clinical guidelines for screening have been endorsed by several clinical organizations, and Medicare coverage for screening took effect in January 1998. There is very little information about physician and health system factors that may influence the effective use of colorectal cancer screening. The purpose of this project is to obtain current, nationally representative data on the physician and health system factors that may influence the use of screening and diagnostic follow-up for the early detection of colorectal

cancer in community practice. The results will be useful in:

- Planning intervention and demonstration research studies aimed at translating the results of controlled trials of screening efficacy into effective community screening practice.
- Interpreting national surveys on patient self-reported use of colorectal cancer screening modalities.
- Designing national surveillance studies for monitoring the performance of screening in the community setting.

Status: A survey services contract was awarded in September 1998. Separate surveys of primary care physicians, specialist physicians, and health plans were developed. Surveys were fielded in late 1999. An analysis of screening rates based on Medicare claims data from an independent sample of Medicare physicians is under development.

96-050 **Influenza and Pneumococcal Analytic Reports**

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|---|---|
| Project No.: | 500-96-0516/02 |
| Period: | September 1996-January 2002 |
| Funding: | $439,420 |
| Award: | Task Order |
| Principal Investigator: | Celia H. Dahlman |
| Awardee: | CHD Research Associates, Inc.<br>5515 Twin Knolls Road, No. 322<br>Columbia, MD 21045 |
| HCFA Project Officer: | Lawrence LaVoie<br>Kansas City Regional Office |

Description: This task order is to develop research data bases from the HCFA Medicare claims data and use them to analyze the epidemiology of influenza (flu) and pneumococcal vaccination (PPV). The objective is to support research in this subject matter area and to promote increased vaccination activity by health-care providers and a higher rate of coverage for Medicare beneficiaries. National and State-level data findings are distributed to a wide audience and included in materials produced for an annual conference on adult immunization, which is co-sponsored by HCFA and the Centers for Disease Control and Prevention (CDC).

Status: Status by subtask:

- *PPV Claims Data.* Claims records for PPV of Medicare beneficiaries are extracted and merged to create a beneficiary-level PPV research file used to generate annual and cumulative immunization rates. HCFA distributes the research file to the peer review organizations. Annual updates of this PPV file incorporate the latest HCFA National Claims History data. – PPV file update with 1998 claims completed.
- *PPV Flu Conference Tables and Reports.* Using both the PPV file and the latest HCFA flu immunization data file, a series of national and State-specific statistics are produced for HCFA distribution to authorized users and for publication as hand-out materials for the annual Adult Immunization Conference. – 2000 Conference scheduled for March 21-22 in St. Louis, Missouri.

- *PPV and Flu Immunization Rates among High-Risk Groups.* Medicare utilization and enrollment data are linked with the PPV and flu files data to analyze immunization rates of high-risk beneficiaries. – Research file created to CDC specifications and definition of “high-risk" cohorts. Developing specifications for analyses of high-risk groups.
- *Impact of Flu on Aged Medicare Beneficiaries.* HCFA flu file and Medicare program enrollment and utilization data files are linked and summarized to support analysis of impact of flu on aged population. – Research files created and delivered to HCFA.

- *Impact and Cost-Effectiveness of Flu and PPV on Medicare Beneficiaries.* Use Medicare program and PPV and flu files data to create research files and conduct outcomes analyses of PPV and flu immunization of the Medicare population. – Linked files created. Developing methodology to measure the cost-effectiveness of vaccination as a health care service provided to Medicare beneficiaries.

- *Analytic Files of Managed Care Beneficiaries.* Create extract and summary files of Medicare program data on managed care beneficiaries. Provide data processing and analysis support to CDC’s research uses of HCFA Medicare program data, including PPV and flu files and the Medicare Current Beneficiary Survey data. – Extract files created of Medicare claims of all managed care beneficiaries enrolled in 1991-1998; developing specifications of a summary utilization file for this cohort.

- *Verification of Changes in Medicare Health Insurance Claims and Vaccination prior to 1991*. Create cross-reference and supplementary claims files for beneficiaries included in the HCFA Medicare beneficiary five-percent sample, to support longitudinal analyses of beneficiaries' utilization and PPV and flu immunization status. Provide data processing and statistical analysis support to CDC in the access and manipulation of HCFA Medicare program data and available research files to analyze the epidemiology of flu and PPV. – Cross-reference file and supplementary claims files for 5-percent sample beneficiaries created. CDC is developing analytical specifications.

96-219 **Outcomes Project--Medicare State Health Profile 1999**

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|---|---|
| Project No.: | 500-95-0056/03 |
| Period: | September 1996-September 2000 |
| Funding: | $2,146,988 |
| Award: | Task Order |
| Principal Investigators: | Barbara Wynn and Elizabeth Sloss |
| Awardee: | The RAND Corporation<br>1333 H St., NW., Suite 800<br>Washington, DC 20005-4707 |
| HCFA Project Officer: | Benedicta Abel-Steinberg<br>Office of Clinical Standards and Quality |

Description: HCFA contracts with peer review organizations (PROs) in each of the 50 States, and in the District of Columbia, Puerto Rico, and the Virgin Islands. Since April 1993, HCFA has been reshaping PRO program activities through the Health Care Quality Improvement Program (HCQIP). With each succeeding PRO scope of work (SOW), PROs have been engaged in HCQIP projects, including "quality outcomes." In the sixth SOW, PROs will be required to implement projects in six clinical priority areas (acute myocardial infarction (AMI), heart failure, diabetes, breast cancer, pneumonia, and stroke). The outcome measures for the clinical areas include mortality and re-admissions. In order to evaluate the effectiveness of the effort baseline information will be needed, including historical trends as well as follow-up information. HCFA is obtaining information from three data sources: claims, medical records, and surveys. Claims data are readily available and HCFA annually publishes claims data information at the national level in HCFA's annual *Data Compendium* and *Medicare and Medicaid Statistical Supplement*.

This project analyzes claims data at the State level and enhances data with additional diagnosis-specific analyses and analyses of inpatient encounter data from Medicare+Choice organizations, focusing on four of the clinical priority areas: AMI, pneumonia, heart failure, and stroke/transient ischemic attack (TIA)/atrial. The reports will encompass national and State-specific data for each PRO to use in the tasks required in their sixth SOW.

Status: The contractor has provided two of the six deliverables. Page layouts for two additional deliverables were provided and reviewed by HCFA and PRO staff. The contractor has met with staff from the Center for Health Plans and Providers to discuss availability of inpatient managed care encounter data.

97-046 **Data and Analytic Services for Consortium Quality Intervention Activities**

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|---|---|
| Project No.: | 500-96-0026/07 |
| Period: | September 1997-March 2000 |
| Funding: | $499,632 |
| Award: | Task Order |
| Principal Investigator: | Jerry Kowalczyk |
| Awardee: | Jing Xing Health and Safety Resources, Inc.<br>7008-K Little River Turnpike<br>Annandale, VA 22003 |
| HCFA Project Officer: | Benedicta Abel-Steinberg<br>Office of Clinical Standards and Quality |

Description: The project consists of four activities:

- Analyze 1995-1997 Behavioral Risk Factor Surveillance System (BRFSS) data sets for certain denominators based on HCFA's beneficiary populations, performing in-depth analyses and modeling as necessary, and the production of data reports. The analyses produce prevalence estimates by State, region, and total U.S. from the 1997 BRFSS data set, stratified by various demographic attributes. The analyses produce State-specific prevalence estimates from pooled 1995 and 1997 BRFSS data sets, stratified by sex and race/ethnicity--and, if

possible, by education and income--for variables to be specified by HCFA.

- Complete an analysis of smoking-related costs using Medicare Current Beneficiary Survey (MCBS) data. The analyses will use the already developed analytic data set that combines MCBS rounds 1, 4, 7, 10, 11, and 16. Modeling of adjusted and transformed inpatient hospital costs will be conducted.

- Verify the Macon, Georgia, validation study survey data after linking it with HCFA Part A and Part B claims data. As is feasible, three years retrospective linkage and prospective linkage from September 1998 of all Part A, Part B, and managed care encounter inpatient claims data with the complete and incomplete surveys from the 1998 Macon data set. The analyses will produce prevalence estimates from the 1998 linked Macon data set, stratified by various demographic attributes such as sex, race/ethnicity, education, and income levels, for variables to be specified by HCFA.

- Prepare the inpatient baseline rates and data for distribution to peer review organizations' (PROs) in support of the PROs' sixth scope of work.

Status: The project is active.

99-066 **Improving Quality in Long-Term Care**

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|---|---|
| Project No.: | HCFA-99-0100 |
| Period: | April 1999-December 1999 |
| Funding: | $50,000 |
| Award: | Purchase Order |
| Principal Investigator: | Janet Corrigan, Ph.D. |
| Awardee: | National Academy of Sciences<br>Institute of Medicine<br>Board on Health Care Services<br>FO 3110, 2101 Constitution Ave., NW.<br>Washington, DC 20418 |
| HCFA Project Officer: | Sydney P. Galloway<br>Office of Strategic Planning |

Description: HCFA provided funds to support a portion of an ongoing project in the National Academy of Sciences/Institute of Medicine (IOM). Our funding would sponsor an additional meeting of the project committee to further explore and deliberate on its findings and recommendations related to the definition and enforcement of regulatory standards, work-force problems, organizational capacity for quality improvement, and quality measurement/information strategies in long-term care situations.

In 1986, IOM issued the report, *Improving the Quality of Care in Nursing Homes*, which was to serve as a foundation for the Nursing Home Reform Act of 1987. Since then, much has changed including attitudes about those using long-term care, ways of providing care, and strategies for assessing and improving the quality of care. In 1997, with primary funding from the Robert Wood Johnson Foundation, the IOM appointed an expert committee to examine a broader range of long-term care services, recipients, and quality improvement strategies than those considered in the 1986 report. Questions being investigated include:

- What are the demographic, health, and other characteristics of individuals requiring long-term care and how are they changing?
- What are the roles of the various long-term care settings, and how do they relate to other components of community care systems?
- What are the strengths and limitations of existing methods and tools to measure, oversee, and improve quality of care and the outcomes of long-term care?
- How can these methods and tools be improved?
- What is known about the current quality of long-term care in different settings and the extent to which care has improved or deteriorated in the last 10-15 years?
- What is known about the impact of long-term care regulation, especially the Nursing Home Reform Act of 1987?

After working for over a year, the IOM committee concluded that an additional meeting was needed given the complexity of the topics being considered and a number of recent developments in long-term care, including various initiatives by the Department of Health and Human Services. In particular, the committee directed that additional report text be drafted related to payment issues and research directions. This HCFA project provides the support to make this last portion of the work possible.

Status: The final report was in the Academy's clearance process by the end of September. The period of performance was extended through the end of December 1999 to allow this clearance to be accomplished. However, it is apparent that the clearance will involve

additional time and the Project Director is requesting an extension through September 2000.

**HOME HEALTH OUTCOME-BASED QUALITY IMPROVEMENT SYSTEM PILOT DEMONSTRATION**

Description: The goal of this pilot demonstration is to explore the feasibility of establishing a national home health outcome-based quality improvement (OBQI) system using information derived from outcome reports based on the Outcomes and Assessment Information Set (OASIS). OASIS is a standardized core assessment data set created specifically to measure quality of care and outcomes from home health care. As a part of the Conditions of Participation, Medicare-certified home health agencies (HHAs) are required to complete a comprehensive patient assessment for nearly all adult home health patients using OASIS. HHAs are required to report this data on a regular basis to their State agencies. HCFA collects this OASIS data regularly from the States for storage in a national repository. Information from the repository will be used to generate national OASIS outcome reports for dissemination through the States to the HHAs. Using OASIS outcome reports, HHAs will be able to develop quality improvement programs that will help HHAs to identify deficiencies and inconsistencies in care delivery, discover new technologies to improve service delivery, and implement behavioral changes that improve patient care. Under this pilot project, one peer review organization (PRO) is selected as the home health PRO. Four other PROs serve as home health pilot PROs and the home health PRO will also serve as the fifth pilot PRO. Under direction of the home health PRO, the pilot PROs will provide training and ongoing assistance to all HHAs in their respective States to help HHAs implement and manage OBQI programs. The home health PRO will be responsible for developing materials to facilitate proper interpretation of OASIS-based home health outcome reports and for developing a clearing house to collect and distribute information about best practices in home health care. The sharing of new technologies through an information clearinghouse will enable HHAs to quickly adapt new strategies to improve the efficacy of treatment services. Effective use of OASIS outcome information to target deficiencies and improve specific outcomes will lead to more efficient service delivery and higher quality of care. The home health PRO and pilot PROs will also provide consultation to HCFA, Regional Home Health Intermediaries, and State agencies with regard to home health quality improvement activities and outcomes.

00-012 **Home Health OBQI System PRO**

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|---|---|
| Project No: | CSQ-00-0005 |
| Period: | December 1999-March 2002 |
| Funding: | $1,365,517 |
| Award: | PRO Special Study Contract |
| Principal Investigator: | Thomas J. Schaefer, D.D.S., M.S. |
| Awardee: | Delmarva Foundation for Medical Care, Inc.<br>9240 Centreville Road<br>Easton, MD 21601 |
| HCFA Task Leaders: | Armen H. Thoumaian, Ph.D.<br>Office of Clinical Standards and Quality<br>Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

00-013 **Home Health OBQI Pilot PRO - Maryland**

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|---|---|
| Project No: | CSQ-00-0006 |
| Period: | December 1999-March 2002 |
| Funding: | $178,000 (estimated) |
| Award: | PRO Contract Amendment |
| Principal Investigator: | Thomas J. Schaefer, D.D.S., M.S. |
| Awardee: | Delmarva Foundation for Medical Care, Inc.<br>9240 Centreville Road<br>Easton, MD 21601 |
| HCFA Task Leaders: | Armen H. Thoumaian, Ph.D.<br>Office of Clinical Standards and Quality<br>Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

00-014 **Home Health OBQI Pilot PRO - New York**

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|---|---|
| Project No: | CSQ-00-0007 |
| Period: | December 1999-March 2002 |
| Funding: | $690,000 (estimated) |
| Award: | PRO Contract Amendment |
| Principal Investigator: | Theodore O. Will |

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| Awardee: | Island Peer Review Organization, Inc.<br>1979 Marcus Avenue<br>Lake Success, New York 11042 |
| HCFA Task Leaders: | Armen H. Thoumaian, Ph.D.<br>Office of Clinical Standards and Quality<br>Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

00-015 **Home Health OBQI Pilot PRO - Michigan**

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| Project No: | CSQ-00-0008 |
| Period: | December 1999-March 2002 |
| Funding: | $652,000 (estimated) |
| Award: | PRO Contract Amendment |
| Principal Investigator: | Sheryl L. Stogis, Dr. P.H. |
| Awardee: | Michigan Peer Review Organization<br>40600 Ann Arbor Road<br>Plymouth, Michigan 48170 |
| HCFA Task Leaders: | Armen H. Thoumaian, Ph.D.<br>Office of Clinical Standards and Quality<br>Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

00-016 **Home Health OBQI Pilot PRO – Rhode Island**

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|---|---|
| Project No: | CSQ-00-0009 |
| Period: | December 1999-March 2002 |
| Funding: | $450,000 (estimated) |
| Award: | PRO Contract Amendment |
| Principal Investigator: | Marcia K. Petrillo |
| Awardee: | Rhode Island Quality Partners, Inc.<br>9 Hayes Street<br>Providence, Rhode Island 02908 |
| HCFA Task Leaders: | Armen H. Thoumaian, Ph.D.<br>Office of Clinical Standards and Quality<br>Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

00-017 **Home Health OBQI Pilot PRO - Virginia**

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|---|---|
| Project No: | CSQ-00-0010 |
| Period: | December 1999-March 2002 |
| Funding: | $474,000 (estimated) |
| Award: | PRO Contract Amendment |
| Principal Investigator: | Joy Hogan Fozman |
| Awardee: | Virginia Health Quality Center<br>1604 Santa Rosa Road<br>Richmond, Virginia 23229 |
| HCFA Task Leaders: | Armen H. Thoumaian, Ph.D.<br>Office of Clinical Standards and Quality<br>Mary G. Wheeler, M.S., R.N.<br>Office of Clinical Standards and Quality |

99-067 **Cost/Payment Issues Related to Quality Improvement and Error Reduction in Health Care**

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|---|---|
| Project No.: | HCFA-99-0266 |
| Period: | August 1999-September 2000 |
| Funding: | $50,000 |
| Award: | Purchase Order |
| Principal Investigator: | Janet Corrigan, Ph.D. |
| Awardee: | National Academy of Sciences<br>Institute of Medicine<br>Board on Health Care Services<br>FO 3110, 2101 Constitution Ave, NW.<br>Washington, DC 20418 |
| HCFA Project Officer: | Sydney P. Galloway<br>Office of Strategic Planning |

Description: HCFA provided funding for a portion of an ongoing project in the National Academy of Sciences/Institute of Medicine (IOM) - the Quality of Health Care in America (QHCA). Our funding sponsored a workshop, commissioned several expert papers and produced a white paper providing a better understanding of the effects of financial incentives - external and internal to health care organizations - on quality improvement in health care, and developed a decision framework to help policy development related to implementation of quality and patient safety improvements.

The IOM established the QHCA committee in June of 1998. The 19-member committee includes individuals with expertise in health care purchasing, consumer issues, insurance and administration, provision of health care services, health informatics and quality oversight and regulation. The overall objective of the QHCA project is to develop a strategy that will result in a threshold improvement in quality over the next 10 years.

Specifically, the committee was charged with the following tasks:

- Review and synthesis of findings in the literature pertaining to the quality of care provided in the health care system.
- Development of a communications strategy for raising the awareness of the general public and key stakeholders of quality of care concerns and opportunities for improvement.
- Articulation of a policy framework that will provide positive incentives to improve quality and foster accountability.
- Identification of key characteristics and factors that enable or encourage providers, health care organizations, health plans, and communities to continuously improve the quality of care.

The QHCA project produced a series of reports on the following topics:

- Patient safety and medical errors.
- A communications strategy for raising the awareness of key stakeholders regarding quality of care concerns.
- Information technology and quality improvement.
- Characteristics of the 21st century health care system.

With this HCFA support, the QHCA committee further explored payment and cost issues related to quality and patient safety interventions. The QHCA project devoted considerable attention to issues of patient safety. Numerous organizations have implemented patient safety interventions (automated drug order entry systems) and programs (e.g., designation of a patient safety officer and team) during the last 2 years. The QHCA explored a limited number of case studies with emphasis on:

- Identification of capital investments and costs of the programs and equipment.
- Identification of shifts in resource use as a result of the intervention.
- Identification of policy or payment/reimbursement practices that encourage or impede improvements.

It is unclear the extent to which executive leadership in delivery systems employ a well-thought-out framework for evaluating potential quality and safety improvements. Anecdotal information indicates that some health care leaders believe that quality and safety improvements almost always add costs. Other internal impediments to quality and safety improvements include poor alignment of financial accounting systems with clinical processes of care such that clinical program managers and providers confront financial disincentives when implementing improvements and absence of internal capabilities to identify cost elimination opportunities (i.e., waste). The objectives of this HCFA-sponsored portion are to better understand the effects of financial incentives - external and internal to health care organizations - on quality improvement in health care and develop a decision framework to help delivery system executives move toward implementation of quality and patient safety improvements.

Status: The project is underway. The panel meeting is scheduled for March 2000 and the report is expected in September 2000. The Project Director is requesting a time extension through September 2000.

99-088 **BBA Studies of Home Oxygen Equipment**

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|---|---|
| Project Period: | 500-99-CA01/SS01<br>September 1999-September 2000 |
| Funding: | $524,876 |
| Award: | PRO Contract Special Study |
| Principal Investigator: | Jo Ellen H. Ross, RN, MNA |
| Awardee: | California Medical Review, Inc.<br>One Sansome Street, Suite 600<br>San Francisco, CA 94104-4448 |
| HCFA Project Officer: | Amelia R. Jackson<br>Office of Clinical Standards and Quality |

Description: After a fair amount of public discussion concerning overpayment for home oxygen equipment, the Balanced Budget Act of 1997 reduced the payment allowances by 25 percent (effective 1/1/98) and by an additional 5 percent (effective 1/1/99). With these significant payment reductions, the act required that the Government Accounting Office study issues related to oxygen equipment. It also required that HCFA arrange with peer review organizations (PROs) to evaluate access to and quality of home oxygen equipment. This evaluation is being done in two phases. In Phase I, a lead PRO will design the evaluation with the assistance of an organization that has expertise in such evaluations. In Phase II, the national evaluation is carried out.

Status: The PRO in California was selected to design the evaluation and it contracted with National Research Corporation of Lincoln, Nebraska, for evaluation assistance. As of mid-December 1999, this team had

designed the evaluation and was completing a survey of a sample of beneficiaries. Surveys of suppliers and physicians are also planned.

98-252 **Evaluating the Use of Quality Indicators in the Long-Term Care Survey Process**

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| Project No.: | 500-96-0010/03 |
| Period: | September 1998-September 2003 |
| Funding: | $3,934,228 |
| Award: | Task Order |
| Principal Investigator: | Steven Garfinkel |
| Awardee: | Research Triangle Institute<br>P.O. Box 12194<br>Research Triangle Park,<br>NC 27709-2194 |
| HCFA Project Officers: | Sue Nonemaker<br>Office of Clinical Standards and Quality<br>Karen Schoeneman<br>Center for Medicaid and State Operations |

Description: HCFA's goal is to move towards a regulatory monitoring system that allows for appropriate use of indicators to evaluate the quality and appropriateness of care provided to residents and determine a facility's compliance with long-term care requirements of participation. This project will recommend how to integrate quality indicators (QIs) into the regulatory process. These QIs could be used for monitoring and assessing facility performance in numerous domains and could support HCFA and States in undertaking appropriate corrective and enforcement actions. This task order will develop and test (with volunteering State survey agencies) various options for using a variety of QIs to improve the effectiveness and efficiency of HCFA's monitoring of facility performance.

Status: The project is underway.

IM-074 **Breast Cancer Treatment Patterns among Medicare Enrollees in HMOs and FFS**

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|---|---|
| Funding: | Intramural |
| HCFA Project Director: | Gerald F. Riley<br>Office of Strategic Planning |

Description: Differences in treatment patterns between health maintenance organizations (HMOs) and fee-for-service (FFS) settings are of interest because of implications for quality and costs of care. This study used tumor registry data from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program, linked with Medicare administrative records to examine the use of breast conserving surgery (BCS) versus mastectomy for early- stage breast cancer cases in HMOs and FFS. The study also examined the use of adjuvant radiation therapy among BCS patients. The study included all early-stage breast cancer cases diagnosed during 1988-1993 among elderly women entitled to Medicare who resided in SEER reporting areas. The study also compared the distributions of stage at diagnosis between HMO and FFS enrollees.

Status: Results of the study were published in the *Journal of the American Medical Association* (Vol. 281, No. 8, February 24, 1999). The study found earlier stage cases at diagnosis among HMO enrollees compared to women in FFS. Among early stage cases, there was significant variation in treatment patterns between HMOs and FFS, with some HMOs performing significantly more BCS than FFS and others significantly less. There were also significant differences between HMOs and FFS with respect to provision of adjuvant radiation therapy following BCS. Overall, HMO enrollees received radiation therapy more frequently, but there was significant plan-by-plan variation.

IM-089 **Comparison of Use of Preventive Services by Medicare HMO and Fee-for-Service Enrollees**

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|---|---|
| Funding: | Intramural |
| HCFA Project Directors: | Noemi V. Rudolph and Gerald F. Riley<br>Office of Strategic Planning |

Description: Studies have found that health maintenance organization (HMO) enrollees use more preventive services than nonenrollees. However, most of these studies provide limited information about the Medicare population. The fall 1996 round of the Medicare Current Beneficiary Survey includes an expanded managed care sample that allows for national comparisons of Medicare HMO enrollees and nonenrollees. This study compares the use of preventive services by Medicare HMO and fee-for-service enrollees.

Status: The study is expected to be completed by mid-2000.

99-080 **Implemention of Consumer Assessments of Health Plans Study Disenrollment Survey**

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|---|---|
| Project No.: | 500-95-0061/05 |
| Period: | September 1999-November 2001 |
| Funding: | $4,458,022 |
| Award: | Task Order |
| Principal Investigator: | Christina Smith-Ritter |
| Awardee: | University of Wisconsin - Madison<br>Research Triangle Institute<br>750 University Ave.<br>Madison, WI 53706 |
| HCFA Project Officer: | Thomas Reilly, Ph.D.<br>Center for Beneficiary Services |

Description: This project implements the Medicare managed care version of the Consumer Assessments of Health Plans Study (CAHPS) Disenrollment Survey. This is a survey of a sample of Medicare beneficiaries who have disenrolled from each Medicare+Choice contracting health plan eligible for inclusion in the study sample. HCFA is an active participant in the CAHPS effort, a 5-year cooperative agreement headed by the Agency for Healthcare Research and Quality (AHRQ). Under this agreement, the Federal agencies and three grantees have developed a set of standardized survey instruments and reporting formats for the primary purpose of providing comparative information to aid consumers in making more informed health plan choices.

To date, HCFA has sponsored three different Medicare versions of the CAHPS surveys and reporting formats. First was a Medicare version of the CAHPS survey for enrollees (the Medicare CAHPS Managed Care Survey, sometimes referred to as the Medicare Satisfaction Survey). Within the last year, HCFA completed the second annual nationwide administration of this survey. Selected results from this wave were released to the public in January 1999 on Medicare Compare, HCFA's comparative health plan data base on its Internet site at www.medicare.gov. This survey will be ongoing. Second, HCFA has sponsored both the development of a disenrollment version of the CAHPS survey (the Medicare CAHPS Disenrollment Survey) and a Medicare fee-for-service version of CAHPS. HCFA has also developed formats for reporting survey results that are easy for beneficiaries to understand in order to encourage beneficiary use of quality information. HCFA implemented the Medicare CAHPS Disenrollment Survey in the fall of 1999 and will be reporting results to the public in spring of 2000. HCFA also expects to implement the Medicare fee-for-service version of the CAHPS survey in the fall of 2000, with reports available to the public in 2001.

All three surveys include comparably worded questions on such topics as coordination of care, referrals to specialists, ease of obtaining needed care, patient/physician interaction, relations with office staff, customer service, and ease of obtaining specialty services and equipment. Both the fee-for-service and disenrollment versions contain additional modifications appropriate to the unique needs and circumstances of their respective populations. HCFA's effort in this area is designed to provide consumer satisfaction information to beneficiaries in both managed care and fee-for-service programs. This plan comparative information will allow more informed consumer choice, monitoring of plan performance by HCFA, plan quality improvement efforts, and will supply information to meet HCFA’s goals for the Government Performance and Results Act.

Status: In progress.

97-265 **Implementation of the Medicare Consumer Assessment of Health Plans Study (CAHPS)**

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|---|---|
| Project No.: | 500-95-0057/04 |
| Period: | September 1997-December 2000 |
| Funding: | $14,906,147 |
| Award: | Task Order |
| Principal Investigator: | Kathryn Langwell |
| Awardee: | Barents Group, LLC<br>2001 M Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officers: | Elizabeth Goldstein, Ph.D.<br>Center for Beneficiary Services<br>Thomas Reilly, Ph.D.<br>Center for Beneficiary Services |

Description: This project implements the Medicare version of the Consumer Assessments of Health Plans Survey in all Medicare risk and cost managed care plans. In recent years, enrollment in the Medicare managed care program has expanded rapidly and shows no signs of abatement. The rate of growth has exceeded 25 percent per year for each of the last 3 years, bringing the number of beneficiaries now enrolled in managed care plans to just over 5 million or almost 14 percent of the Medicare population, a virtual doubling of the number of enrollees since 1993.

As the program continues to grow, it is anticipated that almost all beneficiaries will have the opportunity to choose between a number of increasingly diverse managed care options (e.g., point of service) and the traditional fee-for-service program. Despite this growth, little data have been collected on beneficiaries' experience in and satisfaction with managed care. At present, there is no nationwide data base which is capable of providing valid and reliable plan-to-plan comparative data on the experience of Medicare beneficiaries enrolled in managed care plans. This lack of reliable plan comparative data has two serious ramifications: beneficiaries are left without sufficient information upon which to choose between managed care and fee-for-service options and among managed care plans, and HCFA is missing critical data it needs to monitor and evaluate plan performance.

To rectify this deficiency, HCFA is conducting a nationwide satisfaction survey of Medicare beneficiaries in managed care plans. Each year a cross-section of Medicare managed care enrollees stratified by plan will be surveyed to assess their level of satisfaction with access, quality of care, plans' customer service, resolution of complaints, and their utilization experience. The primary purpose of the survey is to collect, analyze, and disseminate information to Medicare beneficiaries to help them choose among plans. It will also be used with other available data to monitor and evaluate the quality of care and relative performance of managed care plans, and to compare the satisfaction of beneficiaries in the managed care and fee-for-service systems.

HCFA is requiring all Medicare managed care plans to participate in an independent third party administration of this survey. For each plan qualified to participate, HCFA will draw a random sample of 600 noninstitutionalized beneficiaries per plan. These beneficiaries must have been continuously enrolled for at least one year at the time of the survey administration. With a target response rate of 70 percent, this sampling strategy is designed to produce plan- level estimates at the 95 percent confidence interval, +/- 5 points. In addition, for those plans that have too few beneficiaries from which to draw a sample of 600, HCFA will include the universe of enrollees that meet the criteria. These latter respondents will not be included in statistical analyses and will be noted and described in a separate section of any reports required by HCFA from the contractor.

Status: In progress.

98-231 **Evaluation of Medicare CAHPS/Bulletin/Medicare and You in Kansas City MSA**

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|---|---|
| Project No.: | HCFA-IA-98-48 |
| Period: | May 1998-December 1999 |
| Funding: | $744,622 |
| Award: | Interagency Agreement |
| Principal Investigator: | Christine Crofton |
| Awardee: | Agency for Healthcare Research and Quality<br>2101 East Jefferson Street, Suite 600<br>Rockville, MD 20852 |
| HCFA Project Officer: | Sherry A. Terrell, Ph.D.<br>Office of Strategic Planning |

Description: Year two of this project was funded through an interagency agreement (No. HCFA-IA-99-019) to the Agency for Healthcare Research and Quality (AHRQ). A consortium of organizations in Kansas and Missouri agreed to participate in an AHRQ test of a health plan quality assessment system--the Consumer Assessment of Health Plans Study (CAHPS) report. The report is designed to convey consumer quality ratings about local managed care plans' performance. HCFA joined AHRQ and the coalition to extend the evaluation from private plan enrollees and Medicaid enrollees to the Medicare population in the Kansas City Metropolitan Statistical Area (MSA). The purpose of this study is to learn whether Medicare beneficiaries use comparative quality information to make health plan choices and whether the Medicare information program (print material) is effective. About 2,400 randomly selected residents of the Kansas City MSA will receive selected print materials by mail and be surveyed by telephone. One group will receive general summary information about the Medicare program and the new health plan options available to Medicare beneficiaries (*Medicare and You Bulletin*). A second group will receive the more detailed *Medicare and You 1999 Handbook*. This handbook includes benefits and comparative information but no quality information about the local Medicare health maintenance organizations (HMOs) available in the Kansas City MSA. A third group will receive the handbook and the CAHPS comparative health plan quality ratings of local HMOs based on the Medicare CAHPS survey recently completed by plan members in the area. A fourth group, the comparison group, will receive no information. A follow-up telephone survey to a sample of Medicare-experienced beneficiaries and new enrollees will:

- Determine their basic understanding of the Medicare program (including the differences between original Medicare and managed care).
- Determine their preferences for the type, amount, and sources of Medicare information.
- Determine if the information helps them understand their new health plan choices, or appreciate quality differences across health plans.
- Determine if the information affects their confidence in their current health plan decision.
- Determine if the information is used in their health plan decisionmaking.

Subsequently, focus groups with new, experienced, disabled and dually eligible enrollees will be conducted to complement the telephone survey and learn what study participants thought about the information, how carefully they reviewed it, how well they understood it, and how useful they considered it.

Status: Data gathering from the focus groups and the surveys has been completed. The focus group findings reflect well on both the *Medicare & You 1999* handbook and the Medicare CAHPS report. Most participants understood the main messages of these booklets and thought the handbook in particular was a good reference to save and consult. They considered the handbook most useful for people changing coverage or making an initial health plan decision. Participants noted that the CAHPS report primarily would be useful for people predisposed to joining HMOs. While most respondents had already made their plan choice by the time they received the booklets, some of those enrolled in HMOs used the booklets to confirm previous choices. Participants valued the phone numbers and the plan premium information in the handbook. They would like to have seen premium information in the CAHPS report. Beneficiaries reacted positively to the worksheets in both booklets; however, very few beneficiaries actually completed the worksheets. Participants generally wanted to receive the handbook on an annual basis. When asked about the star comparison chart in the CAHPS report, as has been found in other focus groups with Medicare beneficiaries, only a minority understood the relative nature of the stars (i.e., that getting one star does not necessarily mean that a plan performed poorly). In focus groups composed predominantly of new beneficiaries, there was a desire to have received the handbook as much as a year earlier than they actually did for assistance in choosing a Medicare plan. Dual eligible beneficiaries wanted to see more information in the handbook about Medicare and Medicaid coordination of services and coverage. Nonaged disabled beneficiaries believed the booklets were not clear about plan eligibility criteria for the disabled. For additional insights, the full focus group report is available from the National Technical Information Service as "Kansas City Evaluation of Medicare and You (1999) Handbook and Medicare CAHPS: Results from Focus Groups with Aged, Disabled and Dual Eligible Beneficiaries," accession number PB99-152522.

Preliminary descriptive analyses of survey data suggest that the bulletin, handbook, and CAHPS report materials improved both experienced and new beneficiary knowledge about the Medicare program in Kansas City. As expected, education levels play an important role in health insurance knowledge for this population. A beneficiary knowledge index has been developed to support additional impact analyses. Early multivariate analyses suggest that both the new and experienced beneficiaries who received any Medicare print material were more knowledgeable than those who did not, controlling for education and other socioeconomic variables. At this time, we may infer that Medicare print materials had a positive effect on beneficiary knowledge.

Dissemination of early findings have been presented at the following venues:

- American Health Quality Association 1999 Technical Conference "Learning from the Past, Planning for the Future," Savannah, Georgia, February 4-5, 1999.
- National Medicare Education Program Coordinating Committee Meeting, "Evaluation of the Medicare Consumer Assessment of Health Plan Study (CAHPS) and the Medicare and You (1999) Handbook in Kansas City," Washington, DC, May 12, 1999.
- Association for Health Services Research, Chicago, June 1999, two poster displays: (1) Evaluation of the Medicare CAHPS in Kansas City, and (2) Medicare Beneficiary Reactions to Information on Medicare+Choice Option and Health Plan Quality.
- American Public Health Association Meetings, Chicago, November 1999, two research presentations: (1) "Health Insurance Knowledge Among Medicare Beneficiaries," and (2) "Medicare Beneficiaries Reactions to Materials about Medicare Insurance Options."

Future analyses will examine the impact of the print material on beneficiary decision making in confirming or choosing their health care options.

99-033 **Support for Organizing and Convening a Statistical Expert Panel to Advise HCFA on its Disenrollment Sampling and Implementation Strategy**

Project No.: 500-96-0026/13
Period: June 1999-December 1999
Funding: $59,968
Award: Task Order

Principal Investigators: Jerry Kowlaczyk and Jim Beebe
Awardee: Jing Xing Health and Safety Resources, Inc.
P.O. Box 6655, 1312 Vincent Pl.
McLean, VA 22106-6655
HCFA Project Officer: Christine Smithritter
Center for Beneficiary Services

Description: This project provides support for a statistical expert panel that will guide HCFA on the sampling strategy for its national implementation of a disenrollment survey for beneficiaries in organized health plans. The survey will provide plan comparative information for beneficiaries in making informed choices among health plans. Due to factors such as low disenrollment rates and small enrollment, many plans may not be able to yield sufficient sample size for plan comparative estimates. A variety of statistical techniques and approaches are available to address such issues, but there are tradeoffs involved. In addition, there are different ways in which the disenrollment survey might be implemented pre and post January 1, 2002 when the beneficiaries must stay in the plan for a specified period, referred to as "lock-in." By January 1, 2003 this lock-in period will be one year with a 3-month "window" for disenrollment after the January 1 effective date. These arrangements may dictate very different approaches to survey implementation. The advice will come from a panel of statisticians with special expertise in sampling and survey implementation approaches.

Status: In progress.

99-028 **Expanded Evaluation of Medicare and You Handbook: 2000**

Project No.: 500-96-0010/04
Period: March 1999-May 2000
Funding: $922,890
Award: Task Order

Principal Investigator: Steven A. Garfinkel, Ph.D.
Awardee: Research Triangle Institute
P.O. Box 12194
Research Triangle Park,
NC 27709-2194
HCFA Project Officer: Sherry A. Terrell, Ph.D.
Office of Strategic Planning

Description: The purpose of this project is to establish national measures of Medicare beneficiaries' knowledge of the basic Medicare program and their understanding of new Medicare+Choices available under the Balanced Budget Act of 1997. Knowledge will be measured as a summary statistic--a knowledge index. The program objective is to evaluate National Medicare Education Program (NMEP) print material (Handbook: 2000) and selected information distribution channels (i.e., print, Internet, 1-800-MEDICARE) using the knowldege index. Methodological objectives are to empirically test the effect on:

- The survey response rates of payment incentives to beneficiaries to complete questionnaires.
- Respondent recall of HCFA's national mass mailing versus remailing of the Handbook to sample members.

The policy objectives of the project are to support HCFA strategic plan initiatives, contribute to Government Performance and Results Act program performance reporting, and provide feedback for monitoring and continuous quality improvement of NMEP informational materials directed to the Medicare population over time.

Status: Data collection for the control group who did not receive the handbook began in July 1999 and was completed during September and October 1999 prior to the HCFA national mailings (Handbook: 2000). Data collection for the experimental groups who received the handbook from (1) HCFA and (2) the survey firm with the knowledge questionnaire will be conducted from October - January 2000. Early findings from the incentive payment test suggests as much as a 16-percentage point difference in response rates between beneficiaries who received the incentive (completed and returned the questionnaire) and those who did not. Preliminary knowledge measures and the effect of selected NMEP activities on beneficiary knowledge are expected in the spring of 2000.

94-075 **Development of a Global Quality Assessment Tool for Managed Care**

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|---|---|
| Project No.: | 18-C-90315/9 |
| Period: | September 1994-September 1999 |
| Funding: | $1,579,386 |
| Award: | Cooperative Agreement |
| Principal Investigator: | Elizabeth McGlynn, Ph.D. |
| Awardee: | The RAND Corporation<br>1700 Main Street<br>Santa Monica, CA 90407-2138 |
| HCFA Project Officer: | M. Beth Benedict, Dr.P.H.<br>Office of Strategic Planning |

Description: This project developed and tested a clinically-based method for assessing the quality of care delivered for a broad range of services in managed care health plans. It focused on the quality of care delivered to children and to women under 45 years of age. The clinical criteria were developed and the testing conducted on the women's quality indicators.

Status: This HCFA cooperative agreement closed at the end of September 1999. The work continues with testing the children's quality indicators with funding from other sources..

97-264 **Research and Analytic Support for Implementing Performance Measurement in Fee for Service**

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| Project No.: | 500-95-0058/02 |
| Period: | September 1997-March 2001 |
| Funding: | $1,151,985 |
| Award: | Task Order |
| Principal Investigators: | Nancy McCall and Gregory Pope |
| Awardee: | Health Economics Research, Inc.<br>411 Waverley Oaks Rd., Suite 330<br>Waltham, MA 02452 |
| HCFA Project Officer: | Peggy Parks<br>Office of Clinical Standards and Quality |

Description: HCFA is committed to measuring and improving care for its beneficiaries, independent of payment system. The Balanced Budget Act of 1997 requires HCFA to provide comparable information regarding performance in managed care and fee-for-service (FFS) programs. The Health Employer Data and Information Set (HEDIS) clinical effectiveness measures are currently used in managed care and FFS comparisons, but there is some uncertainty about the applicability of the HEDIS measures, as currently specified, to the FFS sector overall and to FFS group practices in particular.

This project will assist in the production and analysis of the HEDIS measures in the FFS setting. Although the measures used in managed care are a convenient starting point, this project's purpose is to critically evaluate the validity of those measures and to determine whether or not they are feasible in FFS. In fiscal year 1999 this project was modified to establish a National Steering Committee (NSC) to provide technical advice to Health Economics Research, Inc. (HER), regarding the implementation of performance measurement in Medicare FFS. The steering committee will consist of a representative of each of the four Group Practice Study Partners and eight external distinguished clinical or group practice experts with skills and knowledge in one or more of the substantive areas of relevance. This steering committee should draw experts from the American Medical Association, medical specialty societies, and group practice management associations. The committee will also strive to include one or more representatives of managed care plans. Once formed, the NSC will be convened two times which will coincide with HER's major analytic activities.

The project is also responsible for the preparation of two articles for submission to peer-reviewed journals. Their purpose will be to allow for a fuller discussion and broader dissemination of interests and concerns that are addressed at the NSC meetings.

Status: The project is evaluating performance measurement at the national and small geographic area levels and practitioner-specific performance measurement at the group practice level. The small areas correlate with managed care market service area definitions. Five small geographic areas have been selected in Arizona, Georgia, Pennsylvania, Wisconsin, and Washington. Within those small geographic areas, four group practices agreed to participate in this project as our study partners. The study partnerships will assist us in exploring the feasibility of producing these measures at the group practice level.

99-059 **Development and Testing of an Outcomes and Assessment Information Set (OASIS) Accuracy Verification**

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|---|---|
| Project No.: | 500-96-0004/04 |
| Period: | September 1999-April 2001 |
| Funding: | $871,441 |
| Award: | Task Order |
| Principal Investigator: | Peter W. Shaughnessy, Ph.D. |
| Awardee: | Center for Health Policy Research<br>University of Colorado<br>1355 S. Colorado Blvd., Suite 306<br>Denver, CO 80222 |
| HCFA Project Officers: | Heidi Gelzer<br>Center for Medicaid and State Operations<br>Mary Weakland<br>Center for Medicaid and State Operations |

Description: This project will develop cost-effective methods for verifying and ultimately improving the accuracy of the Outcomes and Assessment Information Set (OASIS) data submitted by home health agencies (HHAs) to State agencies and HCFA. A major task under this project is to assess the current system for electronic editing and rejection of OASIS records that have fatal errors, as well as analysis of patterns within OASIS records transmitted by HHAs to the State, and OASIS records maintained at HCFA in a national data base. The contractor will provide recommendations for HCFA concerning what cost-effective enhancements are needed to those components of the electronic OASIS data base system that affect data accuracy, including the electronic edits, testing of additional enhancements, and setting of error tolerances for the system. Another major task of this project is the development, testing, and analysis of a set of prototype accuracy protocols with differing levels of intensity of review and, thus, costs. It is expected that these protocols will include both electronic data analysis (offsite) and onsite verification components.

Status: The project's kick-off meeting was held October 29, 1999, in Baltimore, Maryland.

99-123 **Testing of the Diabetes Quality Improvement Project (DQIP) Abstraction Tool and Measure Specifications in Managed Care**

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| Project No.: | 500-99-NY01/SS01 |
| Period: | September 1999-September 2000 |
| Funding: | $95,353 |
| Award: | PRO Contract Special Study |
| Principal Investigator: | Theodore O. Will |
| Awardee: | Island Peer Review Organization, Inc.<br>1979 Marcus Avenue, First Floor<br>Lake Success, NY 11042-1002 |
| HCFA Project Officer: | Kathleen Winchester<br>Office of Clinical Standards and Quality |

Description: The objectives of this peer review organization (PRO) special study are:

- To validate the conversion of the MedQuest diabetes tool (developed by the Texas Medical Foundation for the Diabetes Quality Improvement Project (DQIP) using the specifications developed by the National Council on Quality Assurance) for six of the eight DQIP measures; to develop specifications for the remaining DQIP measures; and to develop a paper tool for the same measures.
- To test the paper tool in 10 managed care organizations (on approximately 100 or more patient records over a 2-year period of time) to report on the reliability and feasibility of the measures and the tool.
- To compare data derived using the DQIP medical record abstraction tool to data derived using the administrative data specifications in 10 different managed care plans, with different types of information systems, to determine the feasibility of collection and the validity of collection using either of the 2 methods or a hybrid methodology.
- To compare use of medical record abstraction and administrative data in both managed care and fee-for-service(FFS) programs in order to advise HCFA about the validity of comparison of managed care to FFS in the year 2000 when data for all managed care plans and all FFS settings are available.

HCFA has selected diabetes as a national priority for the sixth scope of work for PROs and as a priority for plans (mandatory quality improvement projects) under Quality Improvement System for managed care, and Health Employer Data and Information Set (HEDIS) 2000, based on the DQIP measures in the year 2000. The MedQuest diabetes tool has been modified for use by managed care organization and FFS providers for reporting HEDIS 2000 data for diabetes. In keeping with our responsibility for accountability, there are still

several important tests of these measures that must be completed prior to use of the data for public reporting.

Status: In progress.

99-053 **Complaint Improvement Project (CIP)**

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|---|---|
| Project No.: | 500-95-0061/06 |
| Period: | September 1999-March 2001 |
| Funding: | $269,651 |
| Award: | Task Order |
| Principal Investigators: | David Zimmerman and Katherine Hawes |
| Awardee: | University of Wisconsin - Madison<br>Research Triangle Institute<br>750 University Ave.<br>Madison, WI 53706 |
| HCFA Project Officer: | Marvin Feuerberg, Ph.D.<br>Center for Medicaid and State Operations |

Description: Complaints are viewed as a valuable and unique source of information about the health and safety of nursing home residents. In addition, there are problems in responding appropriately to nursing home complains from residents, their families, nursing home staff, and other sources. In response to these problems, a workgroup was created to develop investigatory protocols. Unfortunately, due to flat-lined survey and certification budgets and a large increase in providers, this group was unable to put in place universal standards and procedures that necessarily require increased resources and budget. Recognizing these resource constraints, a set of investigatory protocols were developed as "tools, not rules." Clearly these protocols are not sufficient and many problems remain (as noted in the recent March 1999 General Accounting Office (GAO) report, "Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents"). The GAO investigation concluded that "...serious complaints alleging harm to residents often remain uninvestigated for extended periods. Such delays do not provide this vulnerable population the protections intended by the federally mandated complaint investigation process.... The combination of inadequate State practices and limited HCFA guidance and oversight have too often resulted in extensive delays in investigating serious complaints alleging harmful situations, a lack of careful review of States' policies and practices, and incomplete reporting on nursing homes' compliance history and States' complaint investigation performance."

This project will address many of the issues identified by the GAO, as well as a number of related problems of abuse and neglect of nursing home residents as required by the Balanced Budget Act of 1997, specifically:

- The use of nurse aide registries by States.
- The extent to which institutional environmental factors contribute to cases of abuse and neglect.
- Whether alternatives to existing sanctions for abuse and neglect might be more effective in minimizing future cases of abuse.

A small, separate HCFA-funded study is underway that will describe how States use nurse aide registries and what is known about the effectiveness of State approaches to reports of abuse by nurse aides. This ongoing study will be completed by November 1999. It is expected that this current project will integrate the findings of the separate study into the larger study and report to Congress.

Status: The project is underway.

99-091 **Geographic Variation in Rates of Cardiac Catheterization and Revascularization in Acute Myocardial Infarction: Results from the HCFA Cooperative Cardiovascular Project**

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|---|---|
| Project No.: | 500-99-NH01/SS01 |
| Period: | September 1999-September 2000 |
| Award: | PRO Contract Special Study |
| Principal Investigator: | Robert A. Aurilio |
| Awardee: | Northeast Health Care Quality Foundation<br>15 Old Rollinsford Road, Suite 302<br>Dover, NH 03820-2830 |
| HCFA Project Officer: | Craig Bagley<br>Boston Regional Office |

Description: This project is a follow-on to the Cardiac Catheterization Project (CCP) Geographic Variation study, which has recently been completed. An article is under review at the *Journal of the American Medical Association*. This article, entitled "Geographic Variation in Treatment of Acute Myocardial Infarction: Results From the HCFA Cooperative Cardiovascular Project," may require additional analyses, revisions and resubmission. Also, an abstract entitled "Geographic Variation in Rates of Cardiac Catheterization and Revascularization in Acute Myocardial Infarction:

Results from the HCFA Cooperative Cardiovascular Project," has been accepted for a podium presentation at the American Heart Association conference. This, too, will require additional analyses in order to turn it into a scientific article for submission to a medical journal.

Status: In progress.

99-093 **Measuring and Improving Quality of Carotid Endarterectomy**

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|---|---|
| Project No.: | 500-99-NY01/SS02 |
| Period: | September 1999-September 2000 |
| Funding: | $1,400,000 |
| Award: | PRO Contract Special Study |
| Principal Investigator: | Theodore O. Will |
| Awardee: | Island Peer Review Organization, Inc.<br>1979 Marcus Avenue, First Floor<br>Lake Success, NY 11042-1002 |
| HCFA Project Officer: | Lindsey Bramwell<br>Office of Clinical Standards and Quality |

Description: The objectives of this study are:

- To improve the quality of care and health outcomes for Medicare beneficiaries undergoing carotid endarterectomy (CEA).
- To support and extend the CEA grant awarded by the Agency for Health Care Policy and Research, now known as the Agency for Healthcare Research and Quality (AHRQ), to Mark Chassin, M.D., M.P.H., to measure appropriateness of patient selection, specific surgical and medical processes of care, and risk-adjusted perioperative outcomes.

Island Peer Review Organization, Inc.'s (IPRO) support of this project will be the abstraction of a statewide sample of CEA cases, whose volume is needed by Chassin to build a risk-adjustment model to study the link between surgical processes and outcomes. IPRO will extend the original scope of the AHRQ project by conducting quality improvement activities on a statewide basis, and measuring the results of these activities. Published studies indicate that CEA can reduce the long-term risk of stroke or death in selected patients with carotid artery stenosis. Stroke is the third leading cause of death and the most common cause of adult disability in the United States. A favorable benefit to risk ratio for CEA requires low rates of surgical morbidity and mortality. The annual incidence of CEA is rising rapidly, a 61 percent increase nationally between 1991 and 1994, and a 79 percent increase in New York State Medicare patients between 1993 and 1995. However, past research has suggested significant quality problems associated with this procedure, including selection of inappropriate candidates, high rates of complication, an inverse relationship between provider volume and complications, and substantial racial disparities in procedure use rates.

Status: In progress.

99-090 **The Development and Internal Validation of a Multivariate Measure of Severity of Illness and Long Term Survival Following Hospitalization for Acute Myocardial Infarction**

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|---|---|
| Project No.: | 500-99-NH01/SS02 |
| Period: | September 1999-September 2000 |
| Award: | PRO Contract Special Study |
| Principal Investigator: | Robert A. Aurilio |
| Awardee: | Northeast Health Care Quality Foundation<br>15 Old Rollinsford Road, Suite 302<br>Dover, NH 03820-2830 |
| HCFA Project Officer: | Craig Bagley<br>Boston Regional Office |

Description: This project is a follow-on to the Cardiac Catheterization Project (CCP) Geographic Variation study, which has recently been completed. In November of 1997 a report was provided of the development and internal validation of a multivariate measure of severity of illness and long term survival following hospitalization for acute myocardial infarction. This project will continue work with Dartmouth Medical School to develop prior work as a journal article and to disseminate the findings. We will continue to allow Dartmouth to work with the CCP data during the next 12 months. This continued access to the data would be used to complete the activities related to the dissemination of these results through publication and presentation of the results at scientific meetings.

Status: In progress.

99-092 **Evaluation of Ambulatory Care Quality Improvement Project (ACQIP) and Managed Care Quality Improvement Project (MCQIP) Data**

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|---|---|
| Project No.: | 500-99-MD02/SS02 |
| Period: | September 1999-September 2000 |
| Funding: | $267,962 |
| Award: | PRO Contract Special Study |
| Principal Investigator: | Thomas J. Schaefer, D.D.S., M.S. |
| Awardee: | Delmarva Foundation for Medical Care, Inc.<br>9240 Centreville Road<br>Easton, MD 21601-7098 |
| HCFA Project Officer: | Barbara Fleming<br>Office of Clinical Standards and Quality |

Description: The objective of this special study is to mine the very rich data base that the three-State ACQIP project and the five-State MCQIP project provide above and beyond the value of the pre- and post-intervention data within each State. These projects were designed to assist with obtaining answers to some key questions concerning measurement methodology and case mix, for example. ACQIP is a three-State (Alabama, Iowa, and Maryland) study involving 300 physicians in fee-for-service practices and assessing care to almost 6,000 patients in those practices. In addition, physician and patient surveys were part of this quality improvement project. The MCQIP study involves five States (California, Florida, Minnesota, New York, and Pennsylvania) and 23 managed care plans in those States. Each of the PROs has analyzed the baseline data on care but some of the very important questions that these studies could address have not been explored. These fall into several categories as follows:

- Appropriateness of the measures (e.g., how many blood pressures must be collected?; is a change in blood pressure from start to end a better measure of quality?)
- Appropriateness of the data source (e.g., can the foot care measure best be obtained from the patient or the medical record?; is the medical record adequate for obtaining those measures such as A1C that can be obtained from the billing records?)
- What characteristics of physicians' practices (e.g., generalist versus specialist, urban versus rural, number of diabetic patients in the practice) or of the patients (age, gender, race) were correlated with improved outcomes (better glucose control, better lipid levels, lower blood pressures, reduced utilization of care)?
- Did patient education or self monitoring as self-reported correlate with any improved outcomes?
- How is case mix best determined (i.e., comparison of patient report versus medical record derived versus administrative data)?
- Are there differences in care, utilization of services, or patient outcomes among patients cared for by generalists versus specialists?
- What characteristics of plans, providers, or of the interventions influenced improvement?

All of these questions were initially designed to be addressed by these studies. Some design changes from the initial plan may preclude some exploration of these questions, but there is a need to return to the original data and obtain as many answers to these questions as possible.

Status: In progress.

99-094 **Special Studies to Support the Implementation of the Medicare Health Outcomes Survey - Cohort II-Baseline Data-Analysis and Dissemination of Data for Quality Improvement**

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|---|---|
| Project No.: | 500-99-AZ01/SS01 |
| Period: | May 1999-May 2000 |
| Funding: | $999,982 |
| Award: | PRO Contract Special Study |
| Principal Investigator: | Lawrence J. Shapiro, M.D. |
| Awardee: | Health Services Advisory Group, Inc.<br>301 East Bethany Home Rd.<br>Suite B-157<br>Phoenix, AZ 85012-1265 |
| HCFA Project Officer: | Sonya Karpiak<br>Office of Clinical Standards and Quality |

Description: This project seeks to improve care in the managed care setting using round two data from the Medicare Managed Care Health Outcomes Survey. It is a continuation of work started in 1998, which used cohort I data. The effort will clean and analyze cohort II baseline data from the Health Outcomes Survey. A process evaluation of the usefulness of year one efforts and a needs assessment of managed care organizations (MCOs) and peer review organizations/quality improvement organizations (PROs/QIOs) will be conducted. The

information synthesis will be reviewed and revised. New performance profiles will be constructed for each MCO. Plans and PROs/QIOs will receive enhanced training.

Status: In progress.

97-262 **Study on Effectiveness of Current Long-Term care Survey and Certification**

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|---|---|
| Project No.: | 500-95-0062/03 |
| Period: | November 1996-September 2000 |
| Funding: | $955,627 |
| Award: | Task Order |
| Principal Investigator: | Allison Walker |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officer: | Marvin Feuerberg, Ph.D.<br>Center for Medicaid and State Operations |

Description: This project began with a study for a report to Congress assessing the effectiveness of the current system of survey and certification of nursing homes. It includes an evaluation of alternative mechanisms for quality assurance (e.g., private accreditation of nursing homes). To this end, 22 substudies were initiated and completed. A report was delivered to Congress in July 1998.

After the study was nearly completed, it became clear that inadequate nurse staffing may be a root cause of many of the problems identified in the report as well as those referred to in testimony in hearings before the Senate Special Committee on Aging. In addition the Secretary was required to conduct ". . . a study and report to Congress . . . on the appropriateness of establishing minimum care giver to resident ratios . . . for skilled nursing facilities." For a number of reasons, work on this study was delayed. As a result of the Senate hearings, the General Accounting Office report, and HCFA's own report, a number of initiatives were announced by the Administration designed to be more responsive to the problems identified, including problems potentially linked to inadequate staffing. Accordingly, the existing contract was modified in September 1998 to conduct, in coordination with HCFA staff, a comprehensive nurse staffing study.

The purpose of this portion of the project is to meet part of the congressional mandate to the Secretary to conduct "...a study and report to Congress...on the appropriateness of establishing minimum care giver to resident ratios and minimum supervisor to care giver ratios for skilled nursing facilities." Currently, HCFA has a general requirement and specific requirements with respect to nurse staffing. The general requirement is that staffing must be sufficient to meet the needs of nursing home residents. There are also specific minimum nurse staffing requirements of 8-hour registered-nurse and 24-hour licensed-nurse coverage per day. This minimum is the same for a 30-bed facility or a 300-bed facility. A 1996 report on nurse staffing by the Institute of Medicine (IOM) recommended a higher minimum (not a minimum ratio) of 24-hour registered nursing care. The IOM was not prepared to recommend a minimum ratio, in part because there was not sufficient knowledge to appropriately adjust any recommended ratio by the case mix of the patient population.

Although the IOM report provided some information, the essential question raised by the mandate from Congress to the Secretary (whether there exists an appropriate minimum ratio) remains unknown. Consumer advocates argue that the existing requirements are too vague and many facilities do not have sufficient staff to meet the care needs of residents. There are recommended specific ratios for various nursing staff (RNs, LPNs, aides), and these ratios differ by the particular shift (day, evening, night). In general, the recommended minimum ratio is around the average level of staffing required by HCFA. Clearly, if these minimum ratios were adopted or even a more conservative minimum, there could be very substantial increased program costs.

The U.S. Senate Special Committee on Aging hearings and HCFA's nursing home initiatives noted that inadequate nurse staffing was the root cause behind many of the identified problems. HCFA has noted that staffing was probably related to the nutritional and other problems identified and that further study is needed. However, the matter is technically very complex. Thus, any study and report to Congress must be very comprehensive and the findings - either for or against a recommendation for a minimum staffing ratio regulation - very compelling. The data to measure staffing levels must be national in scope with some concurrent validity checks on the accuracy of the reported data. We will need to derive additional staffing measures from Medicaid cost reports, if full-time equivalents can be derived from these data; otherwise, alternative nurse

staffing data sources will need to be secured. The quality indicator outcome measures will also need to be national in scope and derived from multiple data sources. If the findings indicate a strong relation between some minimum nurse staffing ratio and poor outcomes, then the cost and program budget implications need to be carefully examined.

Status: The project is underway.

99-056 **Development and Validation of a Performance Measure Set for the Evaluation of Medicaid Services Rendered to People with Developmental Disabilities**

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| Project No.: | 500-96-0010/05 |
| Period: | September 1999-September 2002 |
| Funding: | $719,003 |
| Award: | Task Order |
| Principal Investigators: | Sara L. Karon and Shulamit Bernard |
| Awardee: | Research Triangle Institute<br>P.O. Box 12194<br>Research Triangle Park,<br>NC 27709-2194 |
| HCFA Project Officers: | Betty Couchoud<br>Center for Medicaid and State Operations<br>Peggy Parks<br>Center for Medicaid and State Operations |

Description: This project is to select and validate a performance measure set that will be used to evaluate the quality and appropriateness of Medicaid services rendered to people with developmental disabilities. It is expected that the measure set developed will be useful within HCFA's regulatory quality monitoring programs and to inform quality improvement activities. The measure set will also be available to provide information to consumers; on system-wide strengths and weaknesses; and to payers of health care, including HCFA, States and private payment sources, for use in evaluating the quality and value of services. HCFA previously commissioned a study on the effectiveness and appropriateness of intermediate care facilities for the mentally retarded (ICF-MR) regulations and survey processes. One recommendation from this work was that HCFA develop a performance measure set for ICFs-MR that could also be used on a voluntary basis by other types of Medicaid service settings for people with developmental disabilities. It was further recommended that HCFA require facilities to provide HCFA with pertinent data for those performance measures in a uniform format that would contribute to a national data base. Such a system would allow facilities to compare themselves with other facilities that have a similar profile and thus improve their management, provide pre-survey information to State survey agencies, and provide HCFA with information to determine the value of the services it is purchasing on behalf of consumers. Equally important, this system would provide information to consumers and advocates to judge the quality of the services they are receiving. While the quality improvement approach has proven to be valuable for measuring and monitoring resident and facility quality for nursing homes, the services provided to people with mental retardation and other related conditions differ. In ICFs-MR, people usually remain in the program for many years and can be relatively healthy while requiring ICF-MR services. In addition, the size of ICFs-MR ranges from 4 to over 1,000 beds. This project will first recommend and then alpha test a performance measure set to determine its utility and feasibility for use in ICFs-MR. An effort will be made to assess information currently collected by States to determine how such information can be used as performance measures. It is expected that further work beyond this project will be required to bring this system to the point of national implementation including, but not limited to, a large scale beta test. Some or all of the performance measure set may prove useful for other types of settings that serve people with developmental disabilities.

Status: In progress.

98-263 **Assessing Readiness of Medicare Beneficiaries to Participate in Informed Health Care Choices**

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|---|---|
| Project No.: | 17-C-90950/1 |
| Period: | August 1998-June 2000 |
| Funding: | $63,192 |
| Award: | Cooperative Agreement |
| Principal Investigator: | James O. Prochaska, Ph.D. |
| Awardee: | Pro-Change Behavior Systems<br>P.O. Box 755<br>West Kingston, RI 02892 |
| HCFA Project Officer: | Sherry A. Terrell, Ph.D.<br>Office of Strategic Planning |

Description: This study will adapt the investigator’s transtheoretical model of health behavior change using the Medicare Current Beneficiary Survey (MCBS) data

to predict a Medicare beneficiary's readiness to make an informed decision about his/her Medicare health insurance plan choice. The model is a mathematical algorithm that assigns/classifies a case to a stage of readiness to make a decision.

Status: The research team has received MCBS data for 1995-1997 from HCFA and prepared related analytic files. Once 1998 MCBS files are available, the transtheoretical model can be applied. A report is expected in the summer of 2000.

99-039 **National Assessment of the 1999 Regional Education About Choices in Health (REACH)**

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| Project No.: | 500-95-0062/06 |
| Period: | July 1999-May 2000 |
| Funding: | $773,018 |
| Award: | Task Order |
| Principal Investigator: | Gary Gaumer |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officer: | Lori Teichman, Ph.D.<br>Center for Beneficiary Services |

Description: This project will assess the 1999 Regional Education About Choices in Health (REACH) campaign outreach activities. The REACH campaign was operated by the HCFA Regional Offices from September 1, 1999 - November 30, 1999, to inform Medicare beneficiaries of their health care options in the annual enrollment period. Specifically, this assessment project assesses the implementation and impact of the core interventions to all audiences, as well as targeted audiences, in the nationally coordinated educational and publicity campaign to inform Medicare beneficiaries, caregivers, partners, and providers about the fundamental features of the Medicare program and the newer, expanded options with managed care plans under Medicare+Choice (M+C). The Balanced Budget Act of 1997 (BBA) established that, in conjunction with the annual coordinated enrollment period in November of each year, HCFA is responsible for providing a nationally coordinated educational and publicity campaign to publicize the M+C options, as well as Medicare program fundamentals, to beneficiaries at the local level. The act required that this program start in 1998. The 1998 campaign provided HCFA with an opportunity to test what outreach activities were the most effective in reaching Medicare beneficiaries. The BBA required that the Special Information Campaign of 1998 be replaced by a "nationally coordinated educational and publicity campaign" in 1999 and beyond. This project assisted in the preparation for the 1999 campaign (commencing on September 1, 1999), with a research methodology and data collection strategy to assess core interventions and other outreach activities that are part of the 1999 campaign.

Status: In progress.

96-005 **Market Research for Providers and Partners**

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| Project No.: | 500-95-0057/03 |
| Period: | September 1996-January 2000 |
| Funding: | $1,194,488 |
| Award: | Task Order |
| Principal Investigator: | Kathryn Langwell |
| Awardee: | Barents Group, LLC<br>2001 M Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officer: | Sherry A. Terrell, Ph.D.<br>Office of Strategic Planning |

Description: HCFA's provider market research efforts support the agency's comprehensive communication strategy. Market research is one component of the overall strategy to enhance interaction between HCFA and its customers and partners and to ensure communications are efficient and cost-effective. This particular task order systematically studied the information needs of providers and other partners (POPs). For market research purposes, providers were defined as physicians, hospitals, Medicare managed care plans and home health agencies (HHAs); other partners were defined as State Medicaid and State Children's Health Insurance Programs (SCHIP). For each group, answers to two questions were sought--what information is needed from HCFA, and how the information can best be provided. The market research methodology included three basic activities:

- To inventory existing information and communications strategies relevant for POPs.
- To conduct focus groups with members or representatives of these groups.
- To survey POPs for information not available from the first two methods.

Respondents' recommendations will be used to inform HCFA's customer communication strategy and to develop innovative service techniques and systems to better meet information needs.

Status: This project has been completed. POPs believe that HCFA uses some effective communication practices. For the most part, POPs are able to obtain most essential information needed for effective operations. However, they have many suggestions about how to improve HCFA communications including how to reorganize and distribute information for both general audiences and more narrowly defined (specialized) provider audiences. Findings are summarized in the following reports available from the National Technical Information Service:

- "HCFA (On-Line): Market Research for Providers--Final Focus Group Report on the Managed Care Module" (June 1997), accession number PB97-180673.
- "HCFA (On-Line): Market Research for Providers--Final Inventory Report on the Managed Care Module" (June 1997), accession number PB97-180681.
- "Market Research for Providers and Others Partners: Final Report on Hospital Communication" (February 1998), accession number PB98-139355.
- "Market Research for Providers and Other Partners: Communications Between Physicians and the Medicare Program" (May 1998), accession number PB98-153737.
- C "Improving HCFA Communication with Hospitals, Physicians and Medicare HMOs--Final Summary Report" (October 19, 1998), accession number PB99-129942.
- C "Findings from the 1998 Medicare Physician Communication Survey" (May 13, 1999), accession number PB99-151029.

Barents held a series of five advisory panel meetings for HCFA's Center for Medicaid and State Operations on June 9, October 8, October 14, November 4, and November 19, 1998, with Medicaid Directors and SCHIP Directors. The purpose of the consultation process was to understand how the Federal government could build partnerships with States to facilitate the new SCHIP outreach activities. Summaries of these meeting are available on the HCFA Children's Health Insurance Program web page at *www.insurekidsnow.gov* under the Outreach Information Clearinghouse button.

Barriers to outreach identified at the above consultation sessions led to the following three additional special topic meetings:

- C "Effective Use of Volunteers in SCHIP/Medicaid Outreach/Enrollment," April 22, 1999.
- C "Development of School Based Outreach Programs," May 25, 1999.
- C "Building Trust and Developing Effective SCHIP/Medicaid Outreach to Immigrant Children," June 9-10, 1999.

Final SCHIP outreach report summaries are available now at the previously cited "insurekidsnow" web site. Reports also will be available from the National Technical Information Service.

The final project activity was a survey of HHAs to access customer satisfaction with Regional HHA carrier performance and communication. A final report is expected at the end of January 2000.

99-063 **HCFA On-Line Market Research for Beneficiaries**

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| Project No.: | 500-95-0057/07 |
| Period: | September 1999-August 2000 |
| Funding: | $5,086,098 |
| Award: | Task Order |
| Principal Investigator: | Ken Cahill |
| Awardee: | Barents Group, LLC<br>2001 M Street, NW.<br>Washington, DC 20036 |
| HCFA Project Officer: | Jack Fyock, Ph.D.<br>Center for Beneficiary Services |

Description: This is a combination of activities related to consumer tests of beneficiary materials. Tasks include inventories of existing regulations, policies, and literature; documentation of consumer reality through consumer research; developing a message strategy and communication plan; developing a dissemination plan and materials; monitoring desired behaviors; and evaluating the process. During the two decades since HCFA was established, the Agency's statutory mission has grown beyond administration of Medicare and Medicaid to include a focus on the HCFA "customer" in purchasing the best value health care (in terms of affordability and quality of care) for its beneficiaries, fostering excellence in the design of its programs, and

communicating information on health plans, health care, and disease prevention. HCFA has made meeting beneficiary needs a major strategic goal. This is understood to encompass not only beneficiary needs for accessible, high-quality health care and the prompt, accurate processing of health claims, but also beneficiary needs for information about program benefits, appeal rights, health plans and provider choices, treatment options, and more.

The Balanced Budget Act of 1997 created an array of new managed care and other health plan choices for Medicare beneficiaries and established a coordinated open enrollment process. It also provided a broad range of beneficiary rights and protections and expanded preventative benefits. Each of these changes requires HCFA to undertake an extensive beneficiary education program. HCFA also is interested in developing and implementing consumer education and communication strategies that satisfy the divergent characteristics and needs of diverse ethnic and racial groups, languages, and cultures. This project will assist in coordinating these activities.

Status: In progress.

99-031 **Telephone Customer Service Strategy--Customer Satisfaction**

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| Project No.: | 500-95-0059/05 |
| Period: | May 1999-November 2000 |
| Funding: | $989,766 |
| Award: | Task Order |
| Principal Investigator: | Joan DaVanzo |
| Awardee: | Lewin-VHI, Inc.<br>9302 Lee Highway, Suite 500<br>Fairfax, VA 22031-1214 |
| HCFA Project Officer: | Brenda Sims<br>Center for Beneficiary Services |

Description: HCFA has undertaken aggressive action to improve its telephone customer service delivery operations through the creation of more beneficiary-centered customer service strategies and programs. This project provides assistance in developing and implementing a nationwide survey of customer satisfaction with telephone service provided by HCFA's Medicare contractors. It will provide technical guidance and support in the development and implementation of a customer satisfaction methodology and put in place processes that will yield specific and standardized measures of customer satisfaction. The project focuses on the extent to which the caller is satisfied with the services provided, including the professionalism and courtesy of the customer services representatives, ease of use of the telephone system, and overall quality of service.

In June 1998 efforts were initiated to identify the current practices of the Medicare contractor call centers. Although a number of the Medicare contractors conduct this type of activity, clearly the procedures are not consistent. Prior to the implementation of caller-satisfaction measuring systems, consistent definitions, concepts, and methodology must be developed for baseline measures of satisfaction that can be generalized to all contractors and which yield sufficient process information for improving the telephone service.

Currently, HCFA delivers Medicare beneficiary telephone customer service through approximately 60 different carriers and fiscal intermediaries. These contractors manage multiple, independent call centers of various sizes. HCFA has placed new requirements on the contractors for conducting beneficiary satisfaction surveys for fiscal year (FY) 1999. Beneficiary satisfaction will be measured through a survey of a random sample of each call center's customers. The survey will assess beneficiaries' satisfaction with the time spent waiting for a representative, the representative's courtesy and professionalism, and other important issues. HCFA has committed to establish a target goal for satisfaction with telephone customer service for FY 2001 as part of the Government Performance and Results Act. This project provides assistance to complete all design and pre-implementation activities necessary to initiate such a system, with implementation of the measurement system to begin in FY 2000. The detailed elements of the project are:

- C Development and deployment of standard satisfaction measurement instrument(s) for Medicare call centers.
- C Development, implementation, and administration of an independent, third-party national survey.
- C Assistance in setting definitions and concepts for HCFA's performance goals.

Status: Workshops and conferences were held in Miami, Florida in June 1999. The communication plan was finalized in June. The Current Practices Report was finalized in September. The survey instrument was developed and pilot tested in August/September and the Final Pilot Report received. The instrument and survey methodology were tested in four call centers (Empire -

Bohemia and Harrisburg and Arkansas Blue Cross Blue Shield in Little Rock, Arkansas - Part A and Part B). The national roll-out training was completed for all Medicare intermediary and carrier call centers in September. During November the project was supporting the call centers in the implementation of the beneficiary satisfaction initiative.

In November and December HCFA will be evaluating the data submitted by the call centers on beneficiary satisfaction. (This will be an ongoing activity through the end of the contract.) By the end of December we anticipate producing a recommendation on the feasibility of an independent beneficiary satisfaction survey for call centers.

96-055 **Program Monitoring of Customer Service and Information Projects**

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| Project No.: | 500-95-0062/02 |
| Period: | July 1996-May 2000 |
| Funding: | $6,435,981 |
| Award: | Task Order |
| Principal Investigator: | Gary Gaumer, Ph.D. |
| Awardee: | Abt Associates, Inc.<br>55 Wheeler Street<br>Cambridge, MA 02138-1168 |
| HCFA Project Officer: | Elizabeth Goldstein, Ph.D.<br>Center for Beneficiary Services |

Description: Abt's contract provides assistance to HCFA in developing program monitoring systems of its customer service and information projects to provide feedback in the context of continuous quality improvement.

Status: In addition to a cross-cutting assessment of the National Medicare Education Program, Abt is monitoring the Medicare Choices Help line and assisting with the development of an enhanced monitoring system of the State Health Insurance Assistance Programs.

97-029 **Evaluation of Customer Service Projects**

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| Project No.: | 500-97-0437 |
| Period: | September 1997-March 1999 |
| Funding: | $169,159 |
| Award: | Contract |
| Principal Investigator: | Lucy Matsik |
| Awardee: | Booz Allen and Hamilton, Inc.<br>8383 Greensboro Drive<br>McLean, VA 22102-3838 |
| HCFA Project Officer: | Elizabeth Goldstein, Ph.D.<br>Center for Beneficiary Services |

Description: This project involved a series of assessments focusing on customer service projects. Examples of such projects were the Western Consortium Trailblazers and a pilot test of the On-Line Call Detail Data/Real Time--a technology for monitoring customer service centers. There were four types of assessments: Formative, Process, Outcome, and Impact.

Status: The project is completed.

99-035 **Analysis of Medicare Beneficiary Baseline Knowledge Data Using MCBS**

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|---|---|
| Project No.: | 500-95-0061/04 |
| Period: | June 1999-June 2002 |
| Funding: | $229,123 |
| Award: | Task Order |
| Principal Investigator: | James M. Robinson, Ph.D. |
| Awardee: | University of Wisconsin - Madison<br>Research Triangle Institute<br>750 University Ave.<br>Madison, WI 53706 |
| HCFA Project Officer: | Sherry A. Terrell, Ph.D.<br>Office of Strategic Planning |

Description: The purpose of this project is to analyze Medicare beneficiary baseline knowledge data which have been previously collected through the Medicare Current Beneficiary Survey (MCBS). The program objective is to evaluate National Medicare Education Program (NMEP) print material (Handbook: 1999 and Bulletin) and selected information distribution channels (print, Internet, 1-800-MEDICARE). The policy objective is to support HCFA strategic plan initiatives, contribute to Government Performance and Results Act program performance reporting, and provide feedback for monitoring and continuous quality improvement of NMEP informational materials directed to the Medicare population over time.

Status*:* The project is in the first of two phases. An analysis plan has been approved for Phase I, MCBS data user agreements executed, and MCBS Access to Care

files for 1995-1997 and associated supplemental files have been received. Phase I data analyses have begun and several working measures of knowledge constructed. A report entitled "A Knowledge Index Technical Note" using Phase I data has been received and is under review. Phase II will extend Phase I analyses using MCBS 1998 Access to Care files including special supplements--Round-23 (beneficiary knowledge) and Round-24 (beneficiary needs). A final report is expected in the summer of 2000.

99-043 **Survey and Evaluation of New Medicare Members of Medicare+Choice Plans**

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| Project No.: | 500-95-0047/07 |
| Period: | September 1999-September 2001 |
| Funding: | $657,583 |
| Award: | Task Order |
| Principal Investigator: | Merrile Sing, Ph.D. |
| Awardee: | Mathematica Policy Research, Inc.<br>600 Maryland Ave, SW., Suite 550<br>Washington, DC 20024-2512 |
| HCFA Project Officer: | Peri Iz, Ph.D.<br>Office of Strategic Planning |

Description: The purpose of this project is to design a survey for and collect data from Medicare beneficiaries who are new members of Medicare+Choice (M+C) plans and to evaluate the effectiveness of the National Medicare Education Program (NMEP) for these beneficiaries. The objective is to understand the special information needs of new Medicare members, their sources of information (who/where), their preferred distribution channels (how), their understanding of the basic (standard) Medicare program, their understanding of their particular M+C plan, and the impact NMEP activities may have on new members' decision to choose an M+C plan or change their plan. This project does not include the disenrollee population. The project will support HCFA strategic plan initiatives, contribute to Government Performance and Results Act program performance reporting, and provide feedback for monitoring and quality improvement to NMEP informational materials directed to the M+C population over time.

Status: The project is in the start-up phase.

98-254 **Developing Health Plan Performance Reports: Responding to the Balanced Budget Act**

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| Project No.: | 500-95-0056/07 |
| Period: | September 1998-June 1999 |
| Funding: | $198,000 |
| Award: | Task Order |
| Principal Investigator: | Beth McGlynn |
| Awardee: | The RAND Corporation<br>1333 H Street, NW., Suite 800<br>Washington, DC 20005-4707 |
| HCFA Project Officer: | Thomas Reilly, Ph.D.<br>Center for Beneficiary Services |

Description: This task order explored at least three different ways to analyze and present quality performance information to the public and identify the tradeoffs involved. This project sought answers to questions such as:

- Should performance measures be combined into a single score?
- How well do different models handle composite calculations, error, missing values, and differences in measures, so that their aggregation is unbiased?
- Given the limited number of Health Plan Employer Data and Information Set and Consumer Assessment of Health Plans Survey performance measures HCFA plans to use for public reporting and performance monitoring, at least in the foreseeable future, what are the tradeoffs between composite measures and the individual scores?

The answers to these questions enabled HCFA to assess to what extent and in what circumstances it can employ some of the existing models to present comparative health play quality performance information to beneficiaries.

Status: The project has been completed.